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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

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## Original Communications.

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### ON OVARIOTOMY.*

BY THOS. KEITH, ESQR., M.D., F.R.C.S.E.

In a period extending over more than fourteen years the mortality in my two hundred and thirty ovariotomies done without antiseptics was 14.5, or nearly one in seven. In the five years immediately preceding the use of the spray the mor-

*While in Edinburgh last summer I had the extreme good fortune to see much of Dr. Keith and witness him do several ovariotomies. The unequaled success attained by Dr Keith in this department of surgery naturally gives a value to his experience, his methods, and his utterances which can not be overestimated. My endeavor was to learn as much of these as I could. That this might be done with the smallest expense of time and trouble to Dr. Keith, I had a stenographer take down such questions as I put and the answers Dr. K. made to them The colloquial style of the paper is thus explained. In order to save space and the reader's time I have in this publication omitted the questions The omission can be of no real importance, however, since Dr. Keith's words will suggest the questions which they were intended to answer.

It is proper to state that the paper has not had the benefit of Dr. Keith's revision. But as containing the latest utterances of the great Scotch ovariotomist, I am sure it will be regarded as a most valuable contribution to the subject of which it treats.—D. W. YANDELL.

tality was but one in ten and a half, while in the last of those five years—the year before I began the use of the spray—there was but one death in twenty-one cases. So you see the mortality was steadily diminishing during all that time. Immediately after I began to use the spray I had two deaths almost at once—both very bad cases. In the first eight under antiseptics there were these two deaths, and then there was a run of eighty without a death. But you must remember the solutions used at first were not very strong. As we went on and got to operating in the hospital we began to use them strong.

At first our greatest success was with the weak solutions. Toward the end we got to using the regular solution we use in every thing—the five-per-cent solution. I had not used this very long when I began to notice that the cases went on quite differently from what they had done before. The night after the operation we had very often high temperature—104°, 105°, 106°, and once 107°. We had never had any thing like that without antiseptics. In the entire two hundred and thirty cases I have referred to, in only two did the temperature rise to 103° the first night, and it never went to 104°, 105°, or 107°. I noticed the difference and wondered how it could be. I did not then think it was the absorption of the carbolic acid that did it, but I know now that it was. It was after seeing a paper by Bantock that that occurred to me. When I began operating in the theater at the infirmary I used the solutions strong (Lister's strength), and frequently we had high temperatures in simple cases. In the first case, which was a simple case without adhesions, the temperature rose to 105° the first night. This was clearly traceable to the absorption of the carbolic acid. Then we began to have this rise frequently; so that there was a sort of general order left with the nurses to put on the ice-bag when the temperature rose to 103°, and often on the first morning after operation when I came in the ice-bag would be on. We had never had occasion to do this before. I recollect a nurse who had nursed about two hundred cases had a patient one day with a high temperature, and I sent along some ice and an ice-bag, and

she returned word that she did not know how to use them. I had forgotten that she had never had to do with a high temperature. There is no doubt the carbolic acid raised the temperature the first night.

My belief in the spray was very much shaken in the course of the session before last. I had a death from acute septicemia in a healthy woman who I am certain would have got well if I had treated her by drainage without antiseptics. During the time I used the spray I had not drained as often as before, though I still drained in the bad cases. I never once lost faith in drainage. Before antiseptics when there was a doubt I drained, but with the spray I trusted this to keep every thing sweet, and often omitted to drain. I did n't drain this woman. There was a good deal of adhesion down behind the pubes and uterus. About twenty ligatures were used, yet I did n't drain, and she died right off from acute septicemia.

Almost the very next case was one in which I could n't stop the bleeding. The tumor was attached to the inside of the ribs—a bad case of adhesion. Here I drained. The woman went on for thirty or thirty-five hours with a rapid pulse, high temperature, and constant vomiting. An immense quantity of red serum and blood had come from the abdomen. Toward morning of the second night she began to improve. It was a clear fight between drainage and septicemia. I am certain the spray did n't help us one bit. The patient would inevitably have gone wrong without the drainage. We compared the two cases afterward, and the reports were almost word for word the same for thirty hours—the temperature and pulse exactly the same; but the one was drained and the other was not. One died; the other recovered. Both operations were done with every possible care; indeed we were especially particular. Nor were they done in the theater, but in a small room. So I do not think there could be any fault in the way the spray was managed. These things shook my faith in it very much, and at the end of last year after having two deaths in quick succession I gave it up altogether in my ovariotomies.

After the very first death from blood-poisoning I began to use the stronger solutions; put the sponges in a one-in-twenty solution—a tremendous strength. Then, operating in the theater, with the students going out and in, there was a constant rush of cold air, and the spray, which used to do quite well at ten or twelve feet, had to be placed within two feet of the woman. The first four cases done in the theater at the beginning of last session had hemorrhage from the kidney, and two of them died. I never had had any thing like that before. It was purely carbolic-acid poisoning; of that I have no doubt whatever. The women who died of it went off quite differently from the other cases. They did n't swell up in the way the other cases did; they did n't have sickness and refuse their food; but on the third day there was hemorrhage from the kidneys. One died—evidently an intense case of carbolic poisoning—and one had convulsions. That settled the thing for me.

I need hardly tell you how carbolic acid affected me in my own person, further than to say it poisoned me too. But I went on for eighteen months or two years; just so long as the patients did n't suffer I worked away, and tried to get through the operation faster; put on the steam; got a big aspirator; did every thing to shorten time. For a long while I did n't ascribe the hemorrhage from my own kidneys to carbolic acid. But I finally began to suspect it. It was Bantock who first called my attention also to this ugly effect of the acid. I was repeatedly ill from it. I had no operations with the spray in the last half of December last year, and I had none in January and February of this year. I had one at the end of March, by which time I was getting pretty well over my former hemorrhages. I was as bad as ever after the operation, and the patient did not recover well. Ever since that I have stopped the spray altogether, as I said, in ovariotomy.

Practically, I have not used antiseptics since, in the proper sense of the word, in my ovariotomies. Sometimes I do use very weak carbolic solutions, but not as spray; at other times I use water alone.

I doubt very much whether the spray is of any use whatever in the operation of ovariotomy.

I do not think I will adopt any of the new antiseptics, as the eucalyptus, etc.

The difference in the percentage of deaths with and without the spray can not at this time be estimated, for so far we have had no death since we quit the spray. Not counting the case you saw me do today, I have had twenty-six cases since March * without antiseptics—at any rate without the spray—and without a death. Add now to these the twenty-six cases before I began the antiseptics, with but one death, and you see I have had but a single death in a total of fifty-two cases done without antiseptics. And you must bear in mind—for it is an important point—that thirteen of these cases were done in the hospital, where septic no less than other dangers are at the maximum.

Since I gave up the spray I have not had any high temperatures—never any thing like 103° in any case; seldom indeed has the temperature gone above 100°. The nurses were astonished at it not rising. I have put an ice-bag on but once since I quit the spray.

I keep the sponges warm. Of course I disinfect them in carbolic acid. After the first wash in soda and hot water they are put into a one-in-twenty solution just before the operation. This is then washed out and they are put into a solution of one in forty or sixty. Sometimes, however, it should be said, I put them in hot water alone.

I use ligatures of silk and catgut—catgut for simple things. When I tie the pedicle it is always with silk. I do not like to do it with catgut. I prepare my own catgut, because in getting it from the makers it is often rotten.

For the external wound I use silk for the deep sutures and horsehair for the superficial sutures. I close the wound as perfectly as I can—as close as if it were a wound on the face. I do not look at it for a week generally. It is then healed.

*Since this was written I think Dr. Keith has done twelve other ovariotomies without a death.—D. W. Y.

I cover it with carbolized gauze, softened with glycerin, about one in eight, and over that a layer of cotton wool and a flannel bandage.

I drain more cases now than when I operated under antiseptics. I became just a little timid, because it was an awkward thing giving up the spray. There is no doubt I trusted the spray would keep every thing sweet, and my assistants used to tell me that I was not operating so well and was not so careful—doing things in a more slovenly way.

I drain where the adhesions are extensive and where the abdomen will not dry. In some women the abdomen will dry without trouble; in others there is a constant oozing going on; and when you can not stop the bleeding, when your sponges are constantly coming up with blood, you must work away with the sponges and strive to remove every particle of moisture. Tie every thing; stop the bleeding and leave the abdomen dry; and when you can't leave it dry, put in a drain. Of course this applies to bad cases only; and you will not get bad cases well without draining.

I put the drainage-tube through the abdominal wall. It is a small, straight glass tube, adapted to the depth of the pelvis. You must see that it does not press injuriously on the rectum. I feel how it is lying on the rectum, and if it is making pressure I shift it up a little bit. I cover it with a sponge and wrap that in an india-rubber cloth for cleanliness. Doing this way you may often drain for a week and not a drop escape on the dressing or the dress, it being all collected in the sponge.

I examine usually within four or five hours to see if any thing is on the sponge. When I began draining it was a new thing, and I used to go every three hours or so and remove what I could from the pelvis. That I know now was oftener than was necessary.

When the stuff will not run out itself I get it out by putting a syringe in the tube and sucking it out. I change the sponge night and morning.

I am not sure but in draining it is a good plan to make the

change under the spray, because with the sweating and flatus there must be a nasty air about the parts; so I think, on the whole, it is better to change under the spray though the operation has not been done under the spray. In the old days I drained ten years without the spray; but I found when I kept the tube going a week it was almost always, but not always putrid. I remember a case where I drained a sarcomatous tumor in a girl who had a double pleurisy. I drained off one hundred and twenty-six ounces without the spray or any thing, and for fourteen days that stuff remained perfectly pure and sweet till I took out the tube. I used just ordinary sponges; nothing else. In four or five days in most cases the tube without some antiseptic would become putrid. But any thing putrid does n't matter in ovariotomy after forty-eight hours.

I formerly kept the drainage-tube in six days or a week, till the serum got quite sweet and pure; but now I take it out generally within forty-eight hours. If the amount comes down to a dram or two I do n't mind taking the tube out, and that without any kind of precautions. After all, though, you must be governed by the quantity that comes.

The most I ever got out by drainage in any one case was two hundred and forty-seven ounces. I got upward of one hundred ounces in another case, and I have frequently gotten forty and sixty ounces. The ordinary quantity is from six to ten ounces. That is got twice a day, night and morning—most of it on the sponge; but sometimes you do not get any thing out on the sponge. Sometimes where there has been bleeding every drop you take out from the pelvis will be almost pure blood. In one of my cases it amounted to twenty or thirty ounces. Nothing whatever came on the sponge. It is occasionally a sort of sirupy stuff. The patient from whom I got the two hundred and forty-seven ounces I drained for fourteen days. It was a case of burst colloid cyst.

The operation being over, I give the patient a little hypodermic morphia immediately when put into bed. It prevents vomiting and keeps her quiet. I give perhaps one sixth or one

fifth or one fourth of a grain, the amount depending on the patient. I give it after the operation and usually again the first night. Indeed I almost always repeat it the first night. It helps the patient to pass the time and enables the nurse to get a rest. In the old days the nurse never got to bed the first night, but sat holding a basin for the chloroform vomiting. Since we took to using ether we have almost no vomiting.

As to food and drink, I give almost nothing the first afternoon. First I give a teaspoonful of water; not iced. A few patients like ice, but I prefer giving every thing hot—almost scalding hot—especially hot water. When there is sick stomach very hot things will often stop the sickness. For the first five or six or eight hours it is better to give the stomach nothing, and during the first night nothing but fluids. If the patient be very thirsty, give liquids, but in small quantities only, lest her stomach do not absorb them and vomiting result.

As regards giving food, we have a sort of rule of thumb—not till flatus has passed. We generally begin with a little tea or gruel; but for the first two or three days patients do not care for much food. If they are weak, give brandy. They may have a little milk, or soda-water and milk, or milk and lime-water. They will not take much. My patients get solid food very sparingly until after the first week, and in many instances not then. Bad cases are better without it till later. I have seen a mouthful of solid food put cases wrong. What goes on after a bad case, where there is a lot of clots and ligatures in the abdomen, is absorption from the abdomen. The third case I operated on twenty years ago died in twenty-three hours, and there was not a particle of blood to be found when we examined the woman immediately after death; it had been absorbed.

We keep the patients warm, put hot bottles about them, and try and get them to perspire a little; keep them perfectly quiet, especially the first day or two, and allow nobody in the room but the nurse.

I secure the action of the bowels by castor-oil. Don't tell patients they are to get it. If you tell them at night that they

are to have a dose of oil in the morning it spoils their rest, and they say they can't take it. Just take it to them and say "take this."

We don't allow them to get out of bed under a fortnight. We let them sit up in a week or ten days, the time depending on the state of the wound.

We remove the stitches in a week or ten days.

If my patients vomit I just let them vomit. If it is bilious vomiting it will go on till the stuff is all off. If it is septic you can do nothing. If the stuff vomited is sour, give soda or fluid magnesia in a little water. The great mass of cases do not vomit at all. There has been an immense improvement as regards vomiting since we gave up chloroform. Since we took to ether patients will sometimes vomit during the operation and thereby rid the stomach of nasty stuff. But we no longer have the vomit of chloroform—a vomit which was so constant that the nurse regularly stood by the bedside with a basin in her hand to catch the vomit. It is true, patients sometimes vomit when they come out from ether, but it is n't that horrid vomiting going on all the first night and all the next day we formerly had. Nor do I mind vomiting so much now as I used to do, especially when I have a drainage-tube in. I rather like it in that case, because it helps empty any fluids that accumulate.

I do not use the catheter if I can help it. I very seldom use it because after two or three introductions it gets putrid, even if you keep it lying in carbolic acid. It is a mistake, I think, to use it at all if you can possibly avoid it. I have patients practice the use of the bed-pan before the operation; it helps their comfort very much, and is a great saving of trouble. You must take the nurse a good deal into account, and make it as easy to her as you can.

I make no other pressure on the abdomen than that made by the bandage. Sometimes where I have not been able to stop hemorrhage I make the pressure strong for an hour or two.

I have never applied ice to the abdomen. I do not see any good in putting on ice. Some patients like ice to suck, but as

a rule I give very little ice any way. Hot water soothes and stops sickness; and then it helps the skin; and it helps absorption. I keep the patient warm if I can. If you give a patient much ice or put it on her head it keeps down perspiration. I don't think I used five pounds of ice in my two hundred and thirty cases before antiseptics; but when I began antiseptics I had very soon to use ice on account of high temperature; but now that I have abandoned antiseptics I no longer have need of ice. Still I should use it now if the temperature went up. I never used it for pyrexia, as they do in London, because I found I did not operate on such healthy women as they do there.

After having once closed it I have never had occasion to open the abdomen, either for hemorrhage or to syringe it. I have several times opened it from below, between the uterus and the rectum, to let out serum; but that was before the drainage days. I had frequently to puncture behind the uterus to get out serum. It was the red serum which killed. When the patient died we were certain to find a lot of this red serum in the pelvis. I was always poking about in this locality. I got into the way of taking the bearings of the uterus immediately after the operation; learned how the cervix was; and I learned that whenever there was much accumulation of stuff in the pelvis the cervix would be found moved away toward the pubis.

You are perfectly safe to put in a needle in such cases. I have often done so and got out red serum; but since the drainage I have needed nothing of the sort, unless there are specially bad symptoms. We never have now those cases of suppuration in the pelvis which we had before we began to drain. We had lots of them where the patient started off with a high temperature. The suppuration didn't often kill them. I don't know why; but they went on and had fever, and by the fourteenth or fifteenth day there would be an escape of pus from the rectum. I am certain they were sometimes saved by puncturing early and letting out this red serum. But with drainage and greater care we don't need to puncture now.

I did once open up an abdomen. A patient took acute sep-

ticemia a week after the operation. The temperature rose to 104°, 105°, and 106°, and in twenty-four or thirty hours she was away down to a skeleton. You see the flesh going off patients in that state at almost every visit. A thorough examination satisfied me that there was no fluid in the pelvis. There had been great adhesions. The woman had a dry tongue, distended stomach, and was sick. I took a few of the stitches out of the wound and put in my finger and felt all about, thinking I might come upon some collection. I broke up some adhesions to the surface of the intestines. My finger came out bringing some putrid stuff. I examined the abdomen—every thing—with my finger. The only bit I did not examine was on the left side, where there had been no adhesions. I thought just after I had done harm by all this poking, but in the course of the night a teacupful of stinking serum came out from the wound. It came from the part where there had been no adhesion, and its escape saved the woman. Without it had escaped I do believe she would have died.

I don't know what to do when septicemia sets in. You may do any thing you like. If the patient is some days or a week on, and bad symptoms come, she will sometimes get well.

I can give no special directions or information as regards diagnosis. Every man must make it for himself. There are no rules which cover all cases.

I have encountered tumors that I could not remove. But it takes a great deal to make me stop now when I am fairly begun; but every now and then I meet with a tumor I can not take out. I have almost always found such tumors malignant, and generally it happens that as soon as you open the abdomen you can see by the way the tumor runs into the tissues that there is no use trying to get it out. In case of a malignant tumor you just shut up the abdomen the best way you can. I have not shut up any for a good while, but such cases must happen sometimes in spite of all the care you take. The worst cases—cases where I have been once or twice completely beaten—are those associated with pregnancy. I was

once completely beaten where the cyst was so adherent that I could make neither head nor tail of it. I simply left it and drained, and in spite of it all the woman recovered. I have also done the same thing in three or four cases where I was certain beforehand I could not get the tumor out. Three of them were drained—at least the first two—and all happened within a fortnight. One was a splendid woman, whose business was to look after Italian refugees, and she had what was supposed to be a fibrous tumor. It grew, and she was dying. When first seen she was blue, vomiting, and had diarrhea. About two gallons of putrid stuff were got out. The cyst was so adherent to the rectum and pelvis that I knew I need not try to take it out. After a week or two she improved a little. The stuff re-collected, and I again made an incision five or six inches long, just as if for operation, turned out a lot of hair and bone, washed out the cavity with chloride of zinc, dried it as thoroughly as I could, and left it to suppurate. Contrary to my expectations, it suppurated but little, and the woman got well. Two or three others whom I treated in that way got well.

The old way of draining in such cases used to fail because the opening was not free enough. The operator was content to put in a tube and leave it there, but he omitted to make a free incision and leave the wound open. Of course you understand that this implies that the cyst is tremendously adherent to the abdominal walls, and is especially true of cases where the great adhesion is in the pelvis and you are obliged to leave the operation unfinished.

The length of the incision is determined by the softness or hardness of the tumor. I make an incision as small as I think I can do with, and never a big one if I can help it. Yet the incision should always be long enough to let in your hand. Formerly I hampered myself by too small an incision. You may, I admit, break down a semi-solid tumor and get it through a small opening, but it is far better to make a sufficient incision. You work with far more ease to yourself, and where there is much adhesion a free opening is absolutely indispensable.

With regard to the time for the operation in the early days we did n't advise an operation till the patient was pretty far through—till it came to be a matter of necessity—and throughout all this time we had very bad cases and extensive adhesions; but now when a patient has a tumor I always say if it is to come out better have it out without loss of time.

The convalescence depends on the strength of patients at the time of the operation. If strong and healthy they are well in a week and going about in a fortnight; but if a woman has a sixty- or eighty-pound tumor, requiring an operation of an hour or two, and there be lots of blood lost and much adhesion, and she has been tapped and weakened, she will not convalesce quickly; not under a month or six weeks.

I tap a great deal. I like it. I never saw any harm from it when properly done; but I constantly see mischief from the effects of bad tapping. In tapping I use the aspirator you saw used today. You may use any needle with the No. 6 or No. 8 catheter, because the stop-cock is the size of a No. 8 catheter. But the smaller the needle is the better, because the greatest risk in tapping, I think, is hemorrhage.

I often tap to gain time if the legs are swollen; and then I frequently tap a small cyst, because a good many small cysts do not refill. I am not speaking of cysts of the broad ligament; but I have had a good many patients—perhaps a dozen—with small cysts—cured by tapping. There was a young lady whom I went to tap. The family wanted the tumor out. I said no, I would tap it; and I took out about sixty ounces of jelly, and she got perfectly well.

Through the aspirator the stuff will run almost as thick as putty. You can even bring the fat out of a dermoid cyst.

I have seen cases where tapping gave a little trouble, but I never saw death from it except once, and that was in a cyst of the uterus. The woman did well enough, though I handled the cyst a good deal the first day or two. She finally got well and went to Glasgow, but a week or two afterward she had acute in-

flammation of the cyst. The physicians wrote asking what was to be done. I said, either tap the thing or have it out. She was tapped, and she died.

I have never injected any fluid into the cyst after tapping. The less you do that the better, I think. In fact, these cysts are ticklish things to meddle with. I tap a great deal, and with the aspirator I see no harm from it. I sometimes aspirate when I am not sure what the fluid is. I just put in a small exploratory aspirator. If I get thin fluid I empty with a fine needle; if I get thick fluid I use a larger needle. The smaller the needle the better, because, as I said, the danger comes from hemorrhage. I constantly see this: Patients are tapped in the country. The tapping is imperfect. The stuff is n't gotten out. The cyst is not adherent. Some of my very worst operations have been after imperfect tapping. The patient has been weakened. Something got into the peritoneum at the time, and when you come to take the tumor out it is just next to impossible. Adhesions come from imperfect tapping. Doctors are constantly tapping the wrong things — semi-solid tumors.

I am very careful to prevent the fluid of the cyst getting into the abdomen. It may do and sometimes does no harm, but it is a mistake to allow it, as well as being unsurgical. But the cyst may contain septic fluid if it has been often tapped; you can't tell beforehand. The stuff may be swarming with bacteria — putrid. When a cyst bursts some patients take it quite quietly; others it kills right off. The accident that you saw happen in the infirmary yesterday of the cyst bursting during the operation never happened to me but once before, and curiously enough in the same room. It came from putting just a little more force on a cyst than it would bear.

Occasionally in operating I empty cysts by the aspirator, because they are sometimes so thin that if you put in the trocar they burst.

Sometimes I detach the adhesions before and sometimes after I empty the sac. If there are bad adhesions in front it is a very difficult thing to say which you had better do. If the adhesions

are below I put in my hand and arm and endeavor to break them up. You must be guided by circumstances. If possible I like to see the adhesions—get a full view of them. I don't put much force on.

The worst adhesions are to the under surface of the liver and right lumbar region, which I think happens in this wise: If the patient has an attack of peritonitis she almost always lies on the right side, and all inflammatory stuff gravitates down there, and thus you come to have the worst adhesions at that point and the most dangerous to deal with. The mesentery is a very nasty place for adhesions.

After tying adhesions to arrest hemorrhage I clip off the ligatures. I do not like to leave long strings about if I can help it. Sometimes you do the one way and sometimes the other—you can't give any rule for doing a thing one way one day and a different way another day. There are almost always two or more ways of getting at the same end.

Each case, after all, has to be a law unto itself. It is a great matter before the operation to make a little plan of what you are going to do. Syme used to think a great deal about his cases, and it is a good plan to turn the case over in your head for a day or two before you operate.

As a rule I cauterize the pedicle. But for the last year I have been using silk ligatures a little. The cautery is a pretty thing, I think. You leave no foreign body in; you are certain to have no bleeding and that the parts will slough and give no irritation. In a case like that today, where I intended when I set out to cauterize and did n't, it was because I found two pedicles and got a lot of bleeding deep down in the pelvis. For after a pedicle is cauterized you must n't touch it much or sponge it much; and knowing that my hands would of necessity be down about the burnt piece while endeavoring to stop the bleeding and cauterize the second pedicle, I just used the ligature instead.

I like the cautery. It has treated me well. Really, I may say that with it the pedicle almost never bleeds; sometimes, but

very, very rarely. The pressure with the clamp must be as even as you can make it. That you do by pulling the pedicle out and in the clamp. Brown's clamp is narrow at the far end, and if the pressure is not even you may be certain there will be bleeding at the wide end. Then in the bit where the vessels are you must burn slow with dull red heat. You may go through the thick piece quickly, but when dealing with the thin piece you must be very gentle with the heat. You must give your mind to drying the bit between the blades. You require to make the blades of the clamp hot so as to dry the tissue which they compress. Give your mind to that. The whole matter of clamp and cautery is a sort of combined forceps-pressure and cautery; it is not cautery alone. Nor will pressure do alone, because pressure by itself will not dry the thing; but when to the pressure you add the cautery the stump goes in almost like a piece of horn, perfectly dry, and no blood can be given out.

I don't know what the critical days are. If the patient gets over twenty-four hours and is well, I am pretty easy. In acute septicemia the mischief begins in from fourteen to sixteen hours as septic peritonitis. When twenty-four hours are over, and the patient's pulse is going down, and she is not sick, and is looking nice, I am pretty easy, especially if flatus has passed. Still, patients sometimes die after that time. There is always an exception. You think matters are all right, and then something comes and upsets your calculation. Then you will sometimes have a death from an obstructed intestine.

I have used the perchloride of iron occasionally to arrest hemorrhage, and occasionally I use the cautery for the same purpose; but I tie every bleeding thing I can with fine catgut. Oozing points do not require to be stopped long. If you stop the bleeding half an hour, that is all you want. The catgut answers every purpose, only you can not take in a great amount of tissue with it. You can take in three times the amount with a silk ligature that you can with catgut; hence it is a saving of time to use silk where the masses you have to tie are large. Always tie the vessels carefully; then always sponge thor-

oughly. The man who does these things as they should be done must be a surgeon and must be doing a lot of surgical work. It is not the midwifery men that will be successful. One must be always at it. A bad ovariotomy will try you more than any operation in surgery, because you must work at such a rate to get through a certain amount of work in a given time. When the operation goes beyond an hour and a half, every five minutes lessens the patient's chance; and when you have fifty or sixty vessels to tie, and many of these difficult to get at, and a lot of sponging and trouble, ovariotomy must be your daily work if you are to do it well. The simple cases, the *ordinary thing*, any body can do.

As regards the second of the points just mentioned, be sure and clean the entire abdomen and all the vessels about it, and notice with special care the parts between the bladder and the uterus—parts so constantly filled with red serum—always looking into that corner, for the reason that if any thing remains it is sure to be found there.

I use the reflector for the purpose of looking in upon the parts. I do n't know any one who uses that except myself. Yet it is an enormous assistance. It enables you to see the bleeding point at once. What a mess I would have had today and what uncertainty in closing that wound without it.

So far as the mere operative work and management of ovariotomy goes, I should say that the essentials of success were strict attention to detail—perfect cleanliness—perfect nursing—perfect quiet, and unremitting care, such as all severe operations in surgery really demand. Stop the bleeding; no matter if your patient is almost dead, stop the bleeding, if this be possible; and when you can 't stop it put in a drainage-tube. Dry the abdomen as thoroughly as you can, and when you can 't leave it dry put in a drainage-tube. Finally, be gentle with every thing.

I do not go in much for fibroids, for they do not kill. A fibroid is n't like an ovarian tumor. The operation of taking

out fibroids is now in the same position that ovariotomy was twenty years ago, though some say otherwise. I think the fibroids that should be removed are the rapidly-growing ones in young women.

I think fibrous cysts should be taken out as soon as you can; but you can not always remove them. I have done nine in all. Fibroids are five times as common as ovarian tumors. I may have seen a couple of thousand. In nineteen cases out of twenty it is simply a matter of inconvenience and waiting until the menstrual period is past. But when you get a woman under thirty with a big fibrous tumor of the uterus say of forty or fifty pounds I think that you should take it out if you can; but unfortunately you can't always do it; it may have grown away down and fixed itself in the pelvis and be adherent every where. Still, some of these cases should be attempted. Women rarely die from fibrous tumors of the uterus. I have seen only two. I never meddle with the pediculated fibroids—fibroids growing off the fundus—because they do n't kill. You subject a woman to great risk the moment you begin to meddle with a fibrous tumor of her uterus. If there were no other risk, that of hemorrhage alone is something fearful.

In the way of internal treatment I think ergot is a great help in fibroids. I make the patients live a quiet life and avoid stuffing themselves with wine and meat; live under the mark, as it were—getting just what they need and no more. By doing that I have seen hundreds of them pass the menopause and get all right; whereas if they had lived differently, had used meat and wine, I do n't believe they would have done so well or got through it so quietly. Of the nine I mentioned eight got well and one died, death I am certain being from carbolic poisoning. These were all cases of large tumors and removed at the vaginal junction along with the ovaries.

There are far too many operations for fibroids just now. The operation has come to be a fashion. I think Verneuil was right when he said that a woman in these days with a tumor in her abdomen has little chance to escape being explored. As a

rule, the cases that do well by operation are the ones where it is not necessary.

As to the operation itself on fibroids, it is identical with ovariotomy as regards care and precaution, though it is a far more deadly thing, besides being an awkward thing to do. I do not like taking out a fibroid tumor, because there is the broad ligament and all that. Five of my cases were done without antiseptics, and all got well. Of the four done under the spray, one, as I have said, died from carbolic poisoning. The kidneys gave out, and the patient got into acute mania.

I have had no experience in extirpation of the uterus for malignant disease, and I do n't think I ever will have any. You do n't get such cases in time, and even though you did the disease will come back.

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## ACUTE HYPERESTHESIA OF THE PERITONEUM, EITHER CIRCUMSCRIBED OR DIFFUSED, FOLLOWING MINOR GYNECOLOGICAL OPERATIONS AND MANIPULATIONS.*

BY SAMUEL C. BUSEY, M.D., WASHINGTON, D. C.

The following report represents the type of a class of cases occasionally occurring in females, of which the predominant clinical feature is pain and tenderness diffused over the entire area of the abdomen, unaccompanied with the other usual symptoms of inflammation:

Mrs. . . . had during a series of years suffered at varying intervals with dysmenorrhea, due mainly to anteflexion of the womb. At several preceding menstrual periods her suffering had been intense and seemed to increase at each succeeding menstruation. A week previous to the expected period, in Janu-

* Read before American Gynecological Society, 1881.

ary, 1881, a very small laminaria tent had been introduced and permitted to remain until expansion was complete. The following period was painless. The February period was passed without the preparatory dilatation and her suffering was quite as intense as at any time before. On Thursday, March 9, one week previous to the expected menstruation, I introduced without difficulty a laminaria tent about the size of an ordinary metallic knitting-needle. Soon after leaving the house the pain began and rapidly increased in intensity, reaching in about forty minutes, when the tent was withdrawn by her husband, a degree of agony never before experienced. The pain began in the womb and was speedily diffused over the entire area of the abdomen. The sensitiveness was so acute that the weight of the bed-clothing could not be borne. Every jar of the bedstead or of the floor of the apartment increased her suffering. Coldness of the extremities, pallor of the face, nausea and vomiting, and vesical irritability took place apparently simultaneously with the hyperesthetic phenomena. A twenty-drop dose of chlorodyne was given and a messenger dispatched for me. I did not, however, reach her bedside until three hours later, and in the meantime a second dose of the anodyne had been administered.

I found her pale, with an expression indicating suffering. Her pulse was feeble, small, and irregular; tongue slightly coated; some nausea; abdomen retracted. The pain though greatly lessened was felt over the entire abdomen, but most acute in the middle hypogastrium. The abdomen, as she lay with lower limbs straightened out, was so tender that no examination could be made. Tympanitis and fever were absent. Ordered hot fomentations to the abdomen, continuance of the chlorodyne as might be necessary, rest, and a bland diet. The next day she was quite relieved, a slight feeling of soreness in the middle hypogastrium only remaining. She continued to improve, and on Sunday afternoon the flow began painlessly. This period was freer from suffering than any during the previous six months, excepting the one in January.

As previously stated, a similar clinical picture has been several times witnessed, perhaps always following some minor gynecological operation or manipulation. What is the pathological condition?

The absence of fever, tympanitis, and effusion exclude inflammation. It is true latent inflammatory processes take place in serous membranes, and post-mortem appearances, not infrequently observed by experienced pathologists, are ascribed to inflammation when the clinical history failed to supply the usual and characteristic symptoms. In such cases, adhesions, exudation, or thickening of the membrane is found.

Dr. Emmet has recently called attention to a septic form of peritonitis (Amer. Jour. Obst., vol. 4, p. 123) without characteristic symptoms, and expressed the opinion that the "more malignant form the peritonitis, the more certain would every characteristic sign be absent." Jacobi has observed a "number of fatal cases of peritonitis, varying through almost every age, with very little elevation of temperature almost up to the last moment of life."

It is true also that inflammatory effusion may take place in the peritoneal cavity and be attended by only such symptoms as may be due to the presence or accumulation of the exudate. The course and type of these modified forms of peritonitis are, however, entirely different from the cases of intensely acute and evanescent suffering, characterized by agonizing pain and exquisite tenderness, either circumscribed or diffused over the entire area of peritoneal expansion. If inflammation is excluded, would not the freedom from fever, rapid subsidence of symptoms, and absence of consequent conditions bar the hypothesis of simple inflammatory hyperemia? Or is it possible that the prompt use of the narcotic and hot fomentations abort the inflammatory process in its initial stage before the symptomatic fever is developed? It may be (and I am not prepared either to deny or affirm it) that local elevation of temperature does occur. If so, it is not complained of by the patient. If present, it, together with the other signs, would presumptively

establish the condition of inflammatory hyperemia, and as conclusively prove the value of the abortive treatment. The theory of inflammation is, however, unsatisfactory, and in the above case would prove too much, inasmuch as it would attribute the cure to the efficacy of a moderate and evanescent narcotic, and pretermit the more logical conclusion that the speedy relief was due to the prompt removal of the cause. If the withdrawal of the tent was, in fact, the remedy, then the assemblage of symptoms was manifestly a neurosis, finding its explanation in the excessive sensibility of the peripheric endings of the sympathetic nerve supplying the part irritated, and in the morbidly heightened excitability of the receptive nerve centers, which was so great as to produce reflexibly the gastric, cardiac, and vasomotor disturbances.

The tent was the exciting cause, and the focus of irritation was located along the cervico-uterine canal. Upon this hypothesis all the symptoms may be explained. The relation of cause and effects may be traced as follows: The pallor and coldness was due to irritation of the vas-motor center, the gastric and cardiac disturbance to irritation of the pneumogastric center, and the diffused pain and tenderness to irritation of the sensory fibers of the sympathetic supplying the peritoneum. It is not improbable, however, that this exaltation of sensibility may have had its cause in the probably existing passive hyperemia of the peritoneal capillaries, the natural result of the emptiness of the superficial integumentary capillaries.

The condition described exhibits a marked resemblance to that assemblage of nervous perturbations recognized as shock, or, perhaps, the lesser disturbance of the nervous equilibrium known as collapse; but the suddenness and acuteness of pain, though not absolutely conclusive, ought to preclude such interpretation of the phenomena, unless it can be shown that a transitory first stage is quickly succeeded by reaction, marked by the initial symptom of pain.

I submit this report, with the accompanying suggestions, to the deliberation and criticism of the Fellows, and will realize my

purpose completely if I succeed in eliciting the opinions and comments of my distinguished colleagues. The clinical picture presented represents, probably, an observation of unusual intensity; but the gradations of suffering, varying from an aggravated to milder forms, sometimes barely sufficiently marked to attract attention, so constantly threaten our confidence in the harmlessness of minor gynecological operations and manipulations, and for the time being disturb the equanimity and self-reliance of the most astute diagnostician, that I hold it a duty, at least to myself, to solicit the views of those Fellows whose experience and extensive observation entitle their opinions to preëminence in gynecological practice.

*Note.*—Pain may be excited at any part of the course of a sensory nerve, from center to periphery; the sensation, however, is always referred to the peripheral ending. (Law of eccentric perception.) As regards sensations of pain, it is worthy of notice that the sufferer is unable to locate it *accurately*. He succeeds best when the interference causing the pain acts upon a small peripheral area (e. g. prick of needle). When, however, the excitation occurs in the trunk of the nerve, or in the center, or in nerves whose endings are inaccessible (viscera), then there is non-localizable pain (e. g. colic). To *severe pain* is furthermore added that the phenomenon of *irradiation* easily shows itself, by which localization becomes impossible.

The *intensity* of pain depends in the first place upon the excitability of the sensory nerves, and in this respect there exist, upon the one hand, considerable individual fluctuations; upon the other we find some nerves (for example, trigeminus and splanchnic) distinguished by excessive sensibility over all others. The greater the number of nerve-fibers affected the greater the pain.—*Landois, Lehrbuch der Physiologie des Menschen, p.* 888.

*Irradiation.*—The conduction of *painful* sensations takes place through the posterior roots, and thence throughout the *entire gray substance.*

Inasmuch as conduction of pain takes place throughout the entire gray substance, and inasmuch as the excitation of pain

extends within the gray substance in direct proportion to the intensity of the painful interference, we find an explanation of the so-called *irradiation* of painful sensations. In violent pains, viz. the pain appears to *irradiate* from the point of origin over a greater territory; thus, for example, in violent toothache, originating from a certain tooth, pain irradiates at once over the entire maxillary region, even over the whole half of the head. (P. 714.)

To the irritations in the territory of the sensory nerves of the sympathetic belong the painful affection in the lower abdominal and sacral regions, called neuralgia, hypogastrica, hysteralgia, etc., which are localized in the several plexuses of the sympathetic. (P. 699.)

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## BROMINE TOPICALLY IN CHANCROIDS AND CHRONIC ULCERS.

BY J. L. ROBINSON, M.D.

Within the past few months I have had opportunity of testing bromine as a local application to chancroids and chronic ulcers associated with syphilis, as seen in the U. S. Marine Hospital in this city. The following is the formula used: ℞. Bromine, one part; water, three parts; bromide of potash, q. s. to make a solution. To be applied once daily by means of a mop made of cotton wool.

I subjoin a very brief report of a few of the cases treated:

CASE I. W. C., colored, chronic ulcer of two years' standing over the anterior middle third of the tibia. First seen April 1st, when the granulations were large, flabby, and raised, and the surrounding tissues excessively indurated. Applications of nitrate of silver and sulphate of copper were used daily for nearly a month without effecting any change in the character of the sore. May 1st I applied the bromine solution and continued it

daily. Each application was followed by oakum to the sore and a flannel roller to the limb. In two weeks the granulations came to a level with the surface and were of healthy aspect, the surrounding integuments grew soft and pliant, and cicatrization set in. Some weeks after the ulcer was reduced half its former size, and healed rapidly.

CASE II. C. H., colored, admitted June 30th, having a large ulcer of six months' standing, situated as in Case I and altogether of similar character. The bromine, oakum, and the roller were at once applied. Improvement was noticeable from the first day, and a speedy cure seems assured.

Case III. S. H., white, admitted July 12th, with an ulcer of both legs just above the internal malleoli. Much the same appearance as in cases just described. The same treatment effected almost at once the most striking change, and in four weeks the patient was discharged cured.

CASE IV. A. L., colored, admitted July 2d, ulcer four square inches in size of six months' standing, situated just above the ankle on the inner side of the right leg, cup-shaped, covered with a greenish slough, and made offensive by a fetid ichorous discharge. The bromine, etc. quickly reduced the ulcer two thirds in size, besides converting it in all respects into a healthy sore which gives promise of uninterrupted and quick cure.

CASE V. J. L., white, admitted August 2d, with a large indolent ulcer of two years' standing immediately above the external malleolus of right leg. Numerous smaller ulcers existed in the region of both ankles. Bromine, oakum, and the flannel roller accomplished much the same results as in the previous cases.

Fifteen-grain doses of the iodide of potassium given three times daily made up the constitutional treatment in the foregoing cases, except in Case I, where cod-liver oil was deemed advisable.

I have also used the bromine in several cases where, after the operation of circumcision, inoculation of the entire raw surface had occurred, with equally good, I might even say with better results than in the leg-ulcers.

LOUISVILLE, KY.

## FOREIGN CORRESPONDENCE.

*My Dear Yandell:* LONDON, October 15, 1881.

In my last letter, which I was compelled to make somewhat shorter than usual, I endeavored to give you some account of the Congress and its doings. I also alluded to the opening of the British Medical Association meeting at Ryde. Since then further details of both meetings have been published in the British Medical Journal, and a brief résumé of these can hardly fail to interest your readers.

I think I may venture to repeat what I said before as to the result of the Congress, that my feeling was one of slight disappointment. Never before had such a wonderful assemblage of brilliant medical genius been brought together, and yet on reading the proceedings of the different sections it does not appear that any so very remarkable additions to our knowledge were made. However, be this as it may, the Congress was emphatically a success and a splendid one. I am proud to say that British hospitality showed itself true to its old traditions, and our visitors will carry away with them very pleasant memories of their visit to England.

Of course one of the greatest features of the Congress, if not the very greatest, was the presence of Professor Charcot, around whom an admiring circle was constantly gathered. His extremely interesting wax model of a woman, a patient for several years at the Salpétriére, and suffering from ataxic affections of the joints, has been given by him to the Museum of St. Thomas's Hospital, where it can be seen and studied at leisure. This extraordinary disease of the joints has never before been described, nor indeed apparently has it been seen until Charcot drew attention to it; and we must conclude with Sir James Paget that "there are instances of a new disease which has lately for the first time appeared, or at least has lately become much more frequent than formerly it was." In the patient of whom the Professor exhibited a model the first symptoms of locomotor ataxy

appeared twenty years ago. Fifteen years ago the disease showed itself in the left knee, and walking became impossible. Four years ago the left shoulder-joint became affected, then the right shoulder-joint and the right hip, and ultimately the articulation of the right jaw. Post-mortem: Many lesions were found which were not suspected in life. For instance, there existed a fracture of the pelvic bone of the right side, which had not given rise to any appreciable symptoms. In this fracture consolidation had occurred on the inner side with considerable production of callus, while externally there was no consolidation and no callus. These lesions present all the character of ataxic lesions of the bones; that is to say, atrophy and erosion of the head of the bone, without the production of stalactites or the ordinary conditions of dry arthritis. Sections of the bone made by Dr. Blanchard show a widening of the Haversian canals as the chief pathological change. The head of the left femur has been completely absorbed down to the great trochanter, without any trace of inflammatory reaction. Further investigations on this subject are urgently needed. I may mention that there is at present in St. Mary's Hospital, London, a patient who is the subject of "Charcot's disease," but I have not yet had an opportunity of seeing the person.

Of all the addresses delivered before the Congress, none created a deeper impression than that given by Dr. Billings. His immense knowledge of medical literature enabled him to deal most successfully with this subject, and the agreeable style and elegant phraseology of his address excited great admiration. On the other hand, the address of Prof. Huxley on the Connection of Biological Science with Medicine fell rather flat. It is indeed not quite clear why Prof. Huxley was invited to address the Congress at all. He is certainly a qualified medical man, being a member of the College of Surgeons, but he has long ago entirely quitted all medical work. However, his address was completely devoid of novelty, being taken from some of his previous productions published under the title of "Critiques and Addresses," and characterized as usual by that dogmatic and absolute tone

which is his characteristic. No one is more intolerant of criticism or reply than the discoverer of "Bathybius Huxleyi," the modern sea-mare's nest, but before an enlightened audience his utterances are not received with the ecstasy with which the select mutual admiration society greets them.

Of course the address of M. Pasteur on Vaccination in Relation to Chicken Cholera and Splenic Fever excited great interest. Though the present direction of Professor Pasteur's investigations tends to the immediate benefit of farmers and agriculturists, the whole matter is intimately connected with human pathology, and indicates the quarter from which very shortly the most important discoveries in connection with medicine and surgery may be expected to come.

On the occasion of the unveiling of the statue of Harvey at Folkestone that patriarch of science, Professor Owen, availed himself of his address to make a vigorous attack on the anti-vivisection fanatics, in the course of which he completely exposed all their absurd misstatements and exaggerations, and showed how important had been the aid of vivisection as means of experiment in gradually perfecting some of the most important operations of surgery. It was a great pleasure to hear the venerable Professor's clear and distinct enunciation, and to see him carrying so, one might almost say jauntily, his more than threescore years and ten. The fanatics whose sentimental folly he ridiculed would not be worth the trouble of replying to were it not that their craze is unfortunately gaining a hold on an increasing number of persons, among whom are some of the influential and most cultured in the country.

The British Medical Association meeting this year was a great success. The choice of the town of Ryde was a very happy one, for that pleasant resort is easily accessible from all parts, and the climate and scenery of the Isle of Wight offer great inducements to all who can manage to leave home for a few days to assist at the important medical gathering. The president for the year was Mr. Benjamin Barrow, a surgeon of the Isle of Wight, very much respected throughout the south of

England for his high character and scientific knowledge. His address was somewhat of a general character, and dealt with a number of the medico-social topics of the day, such as consultation with homeopaths, the vaccination and vivisection questions, and the contagious-diseases acts. The homeopathic question was also gone into at some length by Mr. Jonathan Hutchinson and Dr. Bristowe in their respective addresses to the surgical and medical sections, and their views on the subject have raised again a storm of controversy, which had been gradually dying out since the squabble between Sir William Jenner and Dr. Quain came to an end.

Mr. Martin Coates, surgeon to the Salisbury Infirmary, was president of the surgical section, and took for the subject of his address a new operation devised by himself for the treatment of internal piles. His aim has been to contrive a cutting operation, that while avoiding the pain of strangulation, sloughing, burning, or crushing, would get rid of open wounds, and leave a simple linear incised wound, closed against irritation or poisoning by the septic contents of the intestine. The great feature of the operation is the use of Mr. Coates's clamp. It is made of well-tempered steel, and is seven inches in length, having at one end a simple hinge and at the other a sort of sugar-nipping fixing. The clamp proper is three inches in length, composed of parallel bars separated by a space of one eighth of an inch. At the part nearest the handle are two shoulders which prevent the blades from coming too near each other.

Our great naturalist Professor Darwin has brought out a very interesting work on The Formation of Vegetable Mold through the Action of Worms, with Observations on their Habits. He shows that earth-worms swallow earth for the purpose of extracting nutriment from the organic matter contained in it, but also that they swallow it in the process of burrowing and eject it from the intestine in the form of castings. It is by this habit of removing earth from a considerable depth and laying it on the surface that worms acquire the importance in the economy of nature which has led Mr. Darwin to devote a treatise to them.

"In many parts of England," writes the Professor, "a weight of more than ten tons of dry earth annually passes through their bodies and is brought to the surface in each acre of land. Apart from the importance of this process in agriculture, it is of great importance to the archæologist; for the heaping up of earth over objects not liable to decay preserves them from harm through countless generations. As Lord Bacon finely phrased it, "*Nunquam magis quam in minimis tota est natura.*" There is a report, for the truth of which I can not vouch, that the Professor is about to commence a series of exhaustive experiments to discover what amount of nutriment is absorbed in the course of a year by an average tenia solium, and to show the use of this worm in the economy of nature.

The poor-law medical officers here are all up in arms. Dr. Mortimer Granville said in evidence before a select committee of the House of Commons that one third of the people at present confined in lunatic asylums in this country have no business there at all. In this sweeping assertion he included not only private asylums for the wealthier portion of the community, but also the county pauper asylums. Now before a pauper is admitted to an asylum he is examined by two poor-law officers separately. Each of these officers makes a statement on oath before the magistrate as to the state of the man's mind. So that if we are to believe Dr. Granville, either the poor-law medical officers do not know the difference between sane and insane, or, knowing the difference, they are guilty of the crime of consigning to these "prisons for the innocent" a large number of people who are in possession of *mens sana in corpore sano.*

The British Medical Journal of last week has an interesting article on the obligations of medical men as regards secrecy. The case upon which the question is raised recently came before the Belgian courts. The facts were as follows: A medical man cited before the *Procureur du roi* refused to answer whether he accompanied three persons accused of being engaged in a duel to the spot at which it was alleged to have been fought, and whether he was present at the duel. He gave as his reason

for refusing to answer the questions put to him that such knowledge as he possessed was by reason of his profession of medicine, and therefore under the seal of secrecy which was demanded of him when he was engaged. On the other hand, the court held that the facts concerning which the witness had been questioned could not be considered acts of his profession, and that the latter could in fact only have commenced at the moment at which it might have become necessary to have recourse to a special knowledge in the accomplishment of the duties which were demanded of him. The tribunal condemned the witness to a fine of twenty dollars and costs, and the court of appeal confirmed the judgment. This view, however, is contested by the medical journals, which contend that the professional act commenced, not at the moment at which any wound was actually inflicted, but at the moment when the doctor was summoned because danger of a wound existed.

The election of rector to the University of Aberdeen will take place early in November. The Aberdeen people, for some reason best known to themselves, make a political contest of the election, though what the rectorship of a university has to do with politics no one else can understand. There has been some talk of bringing forward Lord Cranbrook as the conservative candidate. It has now, however, been definitely settled that Sir James Paget will be the nominee of the conservatives. Prof. Bain will, we understand, be proposed by the other party.

New Babylon is at present in a state of war. The Salvation army parade the streets in large bodies, swelled by all the thieves and ruffians from the East End. These Christian soldiers march about pillaging from the stalls in the streets and thoroughly blocking up the thoroughfares through which they pass. They frequently come into collision with other bodies of ruffians who collect for the purpose of opposing them, and with the costermongers whose goods they have stolen. The army are now starting a "Salvation army medical department." They have entered some of their members at the various medical schools and paid their fees. These army medicals are to be seen in the

dissecting rooms of the London hospitals, wearing the uniform of the service to which they belong, which consists in a blue cap with a silver shield, bearing the inscription "Salvation Army," and a blue coat with military stand-up collar, bearing the silver letters "S. A." I wonder that the students have not risen *en masse* and turned out the intruders, for they do not, as a rule, look with favorable eyes on such hybrid fanaticism.

There is an interesting letter in the British Medical Journal of this week from Dr. Ernest Clarke, the assistant chloroformist to St. Bartholomew's, which throws a light on some of the supposed cases of death from anesthetics which have hitherto been shrouded in mystery. The case in point is as follows: J. S., aged forty-two, underwent operation on August 9th by Dr. Godson for ruptured peritoneum. She was brought under the influence of nitrous oxide gas, followed by ether. When the latter was turned on she became rather blue, but soon recovered, and for an hour and a quarter continued to take the ether well. Nine days later, August 18th, she was placed on the table on her left side, no anesthetic being given. As she complained of cardialgia and appeared frightened, she was allowed to remain quiet for a few minutes. Dr. Godson then proceeded to remove the sutures, but desisted on noticing that the patient was blue in the face and had ceased breathing. Drawing the tongue forward and performing artificial respiration restored the patient. Some brandy was given her, and she was sent back to bed. In a quarter of an hour she had a second attack of dyspnea, accompanied by cardialgia and extreme lividity, and before any remedy could be applied she died. The *post-mortem* examination revealed extensive growths on the mitral valves and a clot, evidently *ante mortem*, two inches and a half long, in the right pulmonary artery. There was no evidence of heart-disease during life. Had the patient been under the influence of an anesthetic her death would doubtless have been placed to its credit or rather to its discredit.

One of the P. & O. Company's steamships, the Ceylon, has been fitted up as a private yacht, and is about to start on a trip

round the world, touching at a large number of places of interest. Some of the West End physicians are recommending their patients with incipient phthisis to take the trip, which is to last nine months, in the hope that the beneficial effect of the sea air will eradicate from their lungs the seeds of the disease. There is certainly some hope of its doing so, for the patients will be all the time under the care of medical men especially chosen for the purpose, and special attention has been paid to the ventilation and warming of the vessel. We wish them all "bon voyage," and hope they may have an embryo Mark Twain on board to write an interesting account of the "Innocents'" voyage round the world.

London seems to have been somewhat exhausted by the Congress, and in consequence there is rather a dearth of interesting articles in the medical papers. Also many of the more prominent members of the profession are only now returning from their annual autumnal holiday.

The medical schools are now in full swing for the winter session, having got over the usual preliminaries of contemporary dinners and inaugural addresses. The returns from the various hospitals show a steady increase in the annual number of entries.

# Reviews.

**The Mother's Guide in the Management and Feeding of Infants.** By JOHN M. KEATING, M.D., Lecturer on the Diseases of Children at the University of Pennsylvania, Visiting Obstetrician to the Philadelphia Hospital, Visiting Physician to St. Joseph's Hospital, Fellow of the College of Physicians of Philadelphia, etc. Philadelphia: Henry C. Lea's Son & Co. 1881. 12mo. Pp. 118.

It requires a unique gift or special severe training for a good professional man to prepare a valuable practical book in the field of his profession for popular instruction, and if the good professional man is and for some years has been a teacher of medical science in a college he must be of phenomenal talent if he do not fail of good results in an effort to instruct the lay world in matters whereof he has long been instructing medical students.

Dr. Keating's little volume has much in it that mothers ought to know for the welfare of their children and their own ease and comfort. But it also has some things calculated to lead mothers into wrong doing, and to make them feel, after a little experience, as if it were impossible to raise common children into healthy adolescents if such end can only be obtained by observing all the points made by Keating. A medical student receiving a lecture from a professor is expected to analyze, compare, reason, and act on his rational judgment; a mother receiving instruction from a doctor is expected to regard it as perfect, and obey accordingly. Contemplate a mother's perplexity in an endeavor to follow this instruction implicitly: "Have a clock in the room and teach, from the *hour of its birth*, the infant to sleep until each nursing hour arrives." Then again this instruction will require much care and patience to follow closely: "Let me impress another fact which is constantly overlooked: After a child has nursed it should be placed on its *right* side or back and kept *perfectly quiet;* if placed on its left side, the weight of its liver

pressing upon a full stomach will often cause it to vomit." And, poor unfortunate liver, here is a new indictment against it; but it may rely on the testimony of the anatomists to clear it of the alleged assault on its fellow viscus, for they will bear witness that the liver is a staid member of the community, remaining quietly in its own domicil, and not a tramp wandering all over the abdomen. How it must frighten a young mother to be told authoritatively that her baby's liver is loose and flapping about promiscuously.

Then when the young mother with her offspring—say seven months old—goes to the seashore or the country, Dr. Keating recommends that she provide herself, for the use of her babe, with the following respectable list of the medical man's armamentaria: Bromide of potassium, powdered alum, calomel, milk of assafetida, lime-water, bicarbonate of soda, soda-mint, mustard, castor-oil, rhubarb, essence of peppermint, magnesia, glycerin, pepsin, baby-food, syrup of ipecac, syrup of squills, syrup of lactucarium, vaselin, camphor-water, and valerianate of ammonia These are orthodox medicaments, and in the hands of a cultivated physician are full of promise of good for children; but unfortunately also there is in them a world of mischief for a baby when improperly given; and the average mother is not a cultivated physician, and therefore after she has them neatly labeled and packed will do a superb thing for her baby, when going from home, by leaving the package behind.

As has already been stated, there are many excellent things in Dr. Keating's book—instructions that would be of real service to a mother in the management of her children; but the book is not all good; and who but a physician shall be able to distinguish the one from the other? And this leads to the conclusion that the work should be perused by the profession and its valuable contents given to the laity as they may be needed, and what is not valuable be unrecited. J. F. H.

**Transactions of the Indiana State Medical Society, 1881.** Thirty-first Annual Session, held in Indianapolis May 17, 18, and 19, 1881. Indianapolis Central Printing Co. Pp. 378.

Such stores of possible professional literature are held by the eleven hundred and thirty members of the Indiana State Medical Society that the wonder is that a three days' session did not furnish matter for more than two hundred and twenty-six pages of essays presented by seventeen individuals. The quantity is certainly not exuberant, whether we regard the number who contributed or the extent of their contributions. There seems, however, to have been a feeling pervading the meeting that the future should be securely guarded against the possible hasty influx of an excess in quantity and an unconsidered crudeness in quality, by requiring hereafter that no voluntary papers on scientific subjects shall be admitted to the attention of the society that have not previously been submitted to and recommended by the county society of the member writing it, and this still under the rigid rule that excludes all communications requiring more than twenty minutes to read. And as an additional safeguard against the volume of published transactions being incumbered with valueless matter, the committee on publication are authorized "to alter, curtail, or reject" any dissertation referred to them not belonging to the business proceedings of the society. This is, in effect, saying that the society will henceforth have a good volume of transactions or none, and if hereafter a poor one appears the world will know that the committee on publication have been incompetent or derelict.

These regulations are not all new, but some that are not have been previously incorporated in the code of by-laws, and the minutes of the proceedings indicate that there must be an increased attention to their observance in the future.

For some unassigned reason the publishing committee have printed the debates on the several scientific papers read to the society among the business minutes of the meeting, instead of having them follow immediately the paper that excited them.

This does not seem to be the best method of arranging them. The papers as printed give no indication of whether or not they were discussed, and there being no index by which one may readily find the record of presentation in the minutes in connection with which the debates are printed it will be a mere accident or extraordinary diligence that will lead the common reader to peruse such discussions as have been printed, and failing to read the debate many papers excite is to miss the most valuable service they do.

Undoubtedly the duties of the publishing committee are onerous and exacting, and we should not be too critical in examining their work nor overbearing in our demand for excellence; but, mindful of those limits and obedient thereto, we may still say without injustice that the present volume is of a character to admit of extensive editorial improvement in its successors.

President Harvey's address presents in a narrative and historical way the fact that medicine, like all other things, has attained its present status by a process of evolution. While we honor the attainments and revere the memory of our professional forefathers, we recognize that, starting from the advance they had made, we have added something to their knowledge—we should have fallen below our opportunities if we had not done so—and our descendants, still enlarging upon our acquirements, will be wiser than we. This is the fundamental idea of the address, and is illustrated by the recital of salient facts culled from the past and observed in the present, and by a rational forecast of what is to come.

Two cases of trichinosis are reported by Dr. J. H. Alexander, of Clifty. One patient died after ten weeks' suffering; the other recovered without special treatment.

Several cases of illness are reported by Dr. Wm. Commons, of Union City, assumed to be trichinosis by the author; but only in one case was trichinæ found, and in that one nowhere except in matter taken from a pustule on the face. *Mirabile dictu!* and still more *mirabile visu!* Another surprise in Dr. Com-

mons's paper is that he should be willing on the evidence he adduces to make the assertion that hog-cholera and trichinosis in swine are identical. So startling and romantic were certain parts of this remarkable paper as read to the society that on motion of Dr. Woodburn the society ordered that nothing but the clinical narrative contained in it be published. An examination of the essay as it appears in the volume leads the reader to wonder what could be the character of the part suppressed. There is a possibility, however, that the publishing committee overlooked the order to suppress.

Dr. L. C. Johnson, of Fountain City, contributes a paper on Infectious Diseases, treating the subject with ability, and detailing a series of experiments on animals with diphtheritic poison conducted by himself. Original investigations properly conceived and carried out have a certain value for all, but in the young and enthusiastic who execute them they are a source of instruction unrivaled in value and not to be attained through any other channel. Dr. Johnson is to be congratulated on the production of such a paper, and his labor and its results are commended to the younger members of the society as examples worthy of imitation.

Quinine is the subject of Dr. J. C. Dare, of Bloomingdale, and he presents facts and arguments against the oxytocic powers of the drug that should attract the attention of practitioners who are enamored of the theory that it has valuable qualities in this direction, and he also fairly shakes to its foundation the edifice built on the theory that quinia is a valuable tonic.

Deliberation on Tobacco and its Toxic Effects has inspired Dr. H. Charles, of Carthage, to submit a dissertation that leads one to think that its author regards tobacco as the bane of the world, morally and physically; and indeed this conclusion would seem to be established if Dr. Charles's citation of the opinions of distinguished men in the world, past and present, could be taken as a fair presentation of the truth, the whole truth, and nothing but the truth in the premises. But the enlightened reader can not accord to the author the credit of having

achieved this desirable goal. We shall never arrive at the positive status of an article, be it a food, a drug, or a luxury, while those who write for scientific bodies simply introduce their pet theories and the result of their search among books for the declarations of others that accord with their own imperfectly-elaborated views. However, if a doctor has an ambition to raise a discussion among his assembled *confrères*, he can succeed admirably by delivering a tirade on tobacco. The minutes of the meeting announce that the subject was discussed at length, but the discussion is not reported. No doubt it was amusing and possibly instructing.

Readers will find an agreeable *résumé* of professional ideas concerning erysipelas in the paper of Dr. W. S. Raymond, of Indianapolis, and on page 149 he makes this original point: "I have noticed one peculiarity about erysipelas in a few fatal cases that I do not recollect to have seen mentioned by another; viz. a mottled condition of the skin about the forearms, feet, and legs. The spots bore a considerable resemblance to the bruise-like spots of scorbutis or vibices of purpura." The author details seven cases of erysipelas covering the several varieties of the disease, and all but one fatal—a morally courageous and valuable feature of the address.

Dr. R., under the head of treatment, and speaking of the tincture of the chloride of iron, says that "the drug has constantly increased in popularity during the last twenty-five years, and is likely to continue to be the treatment of the future." Eighteen years ago a surgeon of Chicago made the broad statement in a full meeting of the American Medical Association in that city that whereas in the early days of the war then existing the army hospital surgeons were chary about performing operations because of the danger of erysipelas and pyemia following, but for himself, at the time of speaking, he had had such experience with the iron tincture that after bringing his patient under its influence he undertook any needed operation with as little apprehension that these unfavorable conditions would supervene as if his patient were a vigorous mountaineer in his healthy Alp-

ine home. If Dr. Raymond has found in the subsequent years an increase on this confidence of the Chicagoan in the virtues of the iron solution, it must now be a very perfect reliance indeed. It requires not more, but a different kind of evidence to sustain the high vulnerary position of the tincture of chloride of iron assigned it by Dr. Raymond.

Dr. L. S. Oppenheimer, of Seymour, announces an improved test for sugar in urine, which he assures us, after ample trial, is as simple as Trommer's, as reliable as Fehling's, and absolutely unchangeable. If the Dr. is not mistaken this will prove a great comfort to practitioners who must make their own examinations of morbid urine, and have this to do only at considerable intervals of time. The formula is pure sulphate of copper 50¼ grs., pure glycerin 1 oz. The instructions for use are not quite satisfactory, but probably a part at least of the obscurity arises from incomplete copy or imperfect proof-reading.

In continuation of his previous labor Dr. Enoch W. King, of New Albany, reports one hundred and twenty-eight additional cases of placenta previa collected since his last communication to the society, making the whole number of his tabulated cases at present two hundred and forty. Much credit should be bestowed on Dr. King for his persevering industry in collecting this series of facts and preparing them for professional instruction, as he has so intelligently done. He summarizes the lessons of his arduous labor in a catalogue of twenty-four aphoristic conclusions drawn from an analysis of his cases, all of them pointing with more or less directness to rules of practice to be observed in these exacting emergencies. While these conclusions are doubtless the true inferences to be drawn from the phenomena attending the cases in hand, it would not be difficult perhaps to successfully question their claim to be the very best results that could be obtained by accoucheurs possessed of the fullest knowledge if they were called to manage an equal number of cases in all particulars similar. But this is neither the time nor place to conduct such polemics.

Fourteen obituary notices by Dr. Jas. F. Hibberd, of Rich-

mond, chairman of the Committee on Necrology, of as many members of the society deceased during the year, close this part of the volume. By order of the society these obituaries were curtailed to such length that no one occupies more than one page. J. F. H.

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**Lectures on the Diagnosis and Treatment of Diseases of the Chest, Throat, and Nasal Cavities.** By E. FLETCHER INGALS, A.M., M.D., Lecturer on Diseases of the Chest and Physical Diagnosis, and on Laryngology in the Post-graduate Course, Rush Medical College; Clinical Professor of Diseases of the Throat and Chest, Central Free Dispensary, Chicago. With one hundred and thirty-five illustrations. New York: William Wood & Company. 8vo. Pp. 437. Text-words about 110,000.

Perhaps there was needed a book of the tenor and scope indicated by the title of this volume, but if there were it had escaped the observation of a great many doctors. Certainly if a lecturer has mined out a round lot of new facts of prime importance he ought to embody them promptly in some form accessible to the profession at large for the common service of all practitioners and the welfare of all people to whose cases they are applicable. This, however, does not seem to have been the fortunate condition of the author whose labor is under notice. In fact, there does not appear to be any thing in his book but what is in easy reach in other standard publications, and his manner of repeating what has been told by others has no special charms calculated to make one familiar with his predecessors shelve their books and lay his on the consultation-rack for every-day use. Certain parts of his teachings will answer very well where one has nothing else to consult, but no part of it is calculated to work up an enthusiasm in a man of average pose of sensibilities. J. F. H.

**A Practical Treatise on Impotence, Sterility, and Allied Disorders of the Male Sexual Organs.** By SAMUEL W. GROSS, A.M., M.D., Lecturer on Venereal and Genito-urinary Diseases in Jefferson Medical College, Philadelphia, Surgeon to and Lecturer on Clinical Surgery in the Jefferson Medical Hospital and the Philadelphia Hospital, President of the Pathological Society of Philadelphia, Author of a Practical Treatise on Tumors of the Mammary Gland, Fellow of and formerly Mütter Lecturer on Surgical Pathology in the College of Physicians of Philadelphia, Fellow of the Academy of Surgery of Philadelphia, etc. With sixteen illustrations. Philadelphia: Henry C. Lea's Son & Co. 8vo. Pp. 174.

Dr. Gross demonstrates himself an excellent book-maker in this work. His subjects are well arranged, and treated in a clear and concise manner, and in language of conspicuous elegance and appropriateness. All classes of readers who have need to consult a book on the subjects embraced in the title to this volume will find it most satisfactory as a record of the author's experience, as well as an index to what other reliable practitioners in the same line have written.

Enough of anatomy and physiology are woven into the text to make a scientific basis for the pathological details and therapeutic procedures, and it all flows in such easy sequence and in such expressive words that the perusal is a real pleasure to any interested party who has an admiration for a vigorous, chaste, and instructive style of writing. The volume is not large, but it has much substance; and a full index will aid the busy consulter to find any point he may seek with the minimum of inconvenience and time.

The illustrations are good, and the publishers have sustained their reputation in the make-up of the volume.

# Clinic of the Month.

## ABSTRACTS OF PROCEEDINGS OF THE INTERNATIONAL MEDICAL CONGRESS.

ON THE MODUS OPERANDI OF PATHOGENIC GERMS IN THE PRODUCTION OF DISEASE IN THE HUMAN BODY—Dr. George Harley, F.R.S.

The author adduces clinical as well as pathological data to prove—

1. That all disease-germs produce local lesions as well as constitutional effects.

2. That the local lesions are of two perfectly distinct kinds.

(*a*) At the seat of the germ's introduction, when they enter by contagion or inoculation.

(*b*) In various parts of the body, when they enter, as just stated, or by channels of infection.

3. The local tissue-changes are of three distinct kinds.

(*a*) A primary, which precedes constitutional disturbance.

(*b*) A secondary, which accompanies constitutional disturbance.

(*c*) A tertiary, which follows upon the subsidence of active constitutional disturbance.

4. That both the local lesions and the constitutional disturbance are the direct effect of the chemical changes produced in the tissues and fluids of the body by the natural growth and multiplication of the germs in them, at the expense of the tissues and fluids of the host.

5. That the growth and multiplication of the germs in the human body, though, clinically speaking, a true pathological process, is, in strictly chemical language, an equally true process of fermentation, attended by the evolution of heat and the decomposition of organic matter, as in all other fermentation processes.

RELATION OF RENAL DISEASES TO DISTURBANCES OF THE GENERAL CIRCULATION AND TO ALTERATIONS OF THE HEART AND BLOOD-VESSELS—Sir Wm. Gull, M.D., and H. G. Sutton, M.B.

1. Kidney-disease is associated with or causes changes in the circulation, heart, and blood-vessels variously, according to the kind and seat of the morbid changes in the renal tissues; for example, vascular (arterial or venous) or tubular or mixed (parenchymatous nephritis).

2. Kidney-disease may be dependent upon causes primarily weak-

ening the circulation; for example, causes of general mal-nutrition, phthisis, fever, scrofulosis, alcoholism, syphilis, etc.

3. Defective renal function has a weakening influence on the circulation and nutrition; tissues become choked by edema, enfeebled by anemia and uremia, and generally wasted; for example, mottled or large white kidney, surgical kidney, etc.

4. Kidney-disease may be dependent upon causes primarily leading to thickening of heart and blood-vessels generally, and to obstruction of the interstitial circulation through the several tissues; for example, arterio-capillary fibrosis, climacteric changes.

5. The question as to the effects of kidney disease on the circulation may often with advantage be reversed, namely, as to what is the influence of alterations in the circulation in producing kidney-disease; for example, abnormal venous tension, arterial tension.

6. Many of the changes in organs hitherto considered uremic are referable to tissue-changes capillary and interstitial, atrophic, anemic, effusive, fibroid, etc., and may be independent of defective renal excretion.

On Infective Nephritis—Prof. Bouchard, Paris.

It is well known that albuminuria, generally transitory, occurs in the course of a certain number of infective diseases. It is also known that in a large number of these diseases uremic symptoms and in several of them the lesions of nephritis have been observed. It is known then that in infective diseases symptoms of a nephritis may supervene, which the autopsy confirms.

These kidney-affections, occurring in infective diseases, are infective inflammations of the kidney, or infective nephritis. This is established by the following grounds:

1. During life the same infective agent which occurs in the blood and the morbid fluids is also found in the urine.

2. This infective agent is only found in urines which contain albumen and elements which indicate a lesion of the kidney.

3. This infective agent disappears from the urine at the same time as the albumen disappears.

4. In fatal cases the same agents are found abundantly in the renal tissue.

5. Finally, in all the cases about which the above assertions are made the kidney is found to present the anatomical characters of a nephritis.

Every case of albuminuria which occurs in an infective disease is

not necessarily due to infective nephritis or to nephritis of any kind. Albuminuria may be either thus produced or may be dyscrasic. The albumen in these two kinds of albuminuria presents different physical characters. Infective nephritis with the above characters has been already ascertained to exist in fifteen infective diseases. Infective nephritis may be the starting point of chronic nephritis. The urine may be one of the means by which infective diseases are transmitted.

ON THE CALCIFIED EPITHELIOMA OF THE SEBACEOUS GLANDS—Dr. Albert Malherbe.

Tumors are met with in the skin and subcutaneous tissues presenting the general structure of epithelioma, but having this distinctive feature, that they contain numerous small calcareous granules due to complete or partial calcification of the epithelial masses. Many of these tumors were formerly described as "osteomata of the skin." Twelve specimens will be exhibited at the Congress.

*Pathological Anatomy.* A calcified epithelioma is composed of an enveloping membrane, a stroma, and epithelial masses contained in the stroma, and either completely or partially calcified.

*The Enveloping Membrane* is composed of connective tissue usually somewhat dense. In it are sometimes small collections of cells (centers of invasion) which may assume the epithelial form and become calcified. The membrane itself is never calcified.

*The Stroma* arises from the enveloping membrane forming small columns or partitions supporting a few vessels. The stroma may be composed of embryonic, fibrous, or bony tissue. When it is embryonic or fibrous it invariably contains spaces, varying in size, occupied by giant cells which are destined to produce calcified epithelial cells. When the stroma ossifies it is true bone that is formed. We then see the curious appearance of masses of calcified epithelial cells inclosed in the midst of bony tissue or even in the medullary spaces. The ossification seems to depend on the age of the tumor. The marrow of the medullary spaces is embryonic or fatty, and contains large, thin-coated vessels like great capillaries.

*The Epithelial Masses*, which form about half the volume of the tumor, are composed of polyhedral cells, the protoplasm of which is rendered opaque by granules. The nucleus resists calcification much longer, but is finally also rendered opaque by calcareous granules. Epithelial globes partly calcified are numerous in some specimens.

This being the structure, it is easy to understand the microscopic characters of a calcified epithelioma. Soft and stuffed with calcareous

pulp when young, they become absolutely bone-like and as hard as stones when old.

They contain nine per cent phosphate of lime and two per cent carbonate of lime.

These tumors are always subcutaneous. They vary in size from a pin's head to a fist. When hard, false bursæ may form round them which may inflame and suppurate. Their recognition after removal is easy. The only tumors they resemble are calcified atheromatous cysts, such as are met with in the scrotum. They differ much, however, on microscopic examination; for we see that the latter tumors are formed by the calcification pure and simple of the contents of a sebaceous cyst without the intervention of any neoplastic power.

*Development.* Calcified epithelioma arises in the sebaceous glands. It invades glands already undergoing transformation into atheromatous cysts, but at so early a period that it may almost be considered a primary condition. The stroma is formed by a budding inward of the homogeneous tissue of the wall of the cyst. The processes thus formed subdivide, and as they become older undergo a transformation, first into fibrous tissue and finally into bone. The epithelial masses are developed first from the most external cells of the epithelial contents of the cyst. In other parts the calcified cells proceed from the segmentation of the protoplasm of the giant cells, new epithelial cells being thus formed, which almost immediately become invaded by calcification. The growth of the tumor takes place from the uncalcified part and is arrested by calcification.

*Clinical Characters.* These tumors are non-malignant, and never recur after removal. They are of slow growth, and develop in infancy or youth; more rarely in adult life. They are most common in females.

*History.* These tumors have been confounded by most authors with simple calcification of atheromatous cysts. The first clear account is by Martin Wilckens (*über die Verknöcherung und Verkalkung der Haut und die sogenannten Hautsteine*, 1878). Calcification of epithelial cells has been briefly mentioned by Gluge (1841), Dalrymple (1843), Förster (1855), Lancereaux (1879). Our researches lead us to think that if the specimens of so-called osteoma of the skin at present in pathological museums were re-examined they would almost all have to be re-christened and classed among calcified epitheliomata.

ON PERCUSSION OF THE SKULL IN THE DIAGNOSIS OF DISEASE OF THE BRAIN—Alex. Robertson, M.D., F.F.P.S.G.

Although attention was directed by the writer in 1877 to the value

of percussion of the skull in the localization of disease on the surface of the brain, and Dr. Ferrier ("Brain," 1879) has also insisted on its importance, the subject may still be considered comparatively new to the profession.

The paper first deals with objections against the practicability of transmitting the degree of force employed in tapping the skull with the finger to the surface of the brain. Duret's experimental researches on cerebral traumatism show that in blows on the head a "*cone de dépression*" is formed, which passes deeply in the line of the thrust to the base of the skull. The slight force of percussion will act in a similar way, though it may scarcely extend beyond the cortical substance.

A somewhat analogous instance of the irritation of a morbid part into conscious sensibility is sometimes supplied by disease of the lungs, in percussion over a cavity or softened caseous matter near the surface of the lung.

Clinical experience is one apparently conclusive on the question. Cases of Jacksonian epilepsy and monoplegias are referred to, where the symptoms pointed to the motor region of the convolutions as the seat of disease, and in which percussion of the skull elicited very distinctly deep-seated pain in that part of the head and *nowhere else*. The two kinds of symptoms—the disturbance of function and the developed pain—lend each other mutual support in the localization of the disease. When the convulsive movements are general the pain brought out by percussion at some other part of the head probably indicates the center from which the morbid action spreads to the motor convolutions. In some cases corroboration of the diagnosis is derived from the history of former blows and also from the beneficial effect of treatment over the painful region.

Another objection is that the brain substance is wholly insensitive and the membranes are only slightly sensitive. In reply, it is pointed out that the dura mater and the pia mater, like other fibrous membranes, when in a state of disease and subject to tension, may give rise to severe pain.

The pain in the cases founded on is not induced by mere rubbing or gentle pressure, but by *percussion*. It is therefore inferred that the disease is not in the bone, unless it be in the inner table of the skull; and if it be situated in this part it is of great importance to elicit the fact, as morbid action there usually involves the outer and often the inner membrane and brain itself. However, disease of the bone in adults in most cases is syphilitic, and the pain, as a rule, is such as to stand in no need of artificial development to manifest its existence.

Then follow brief notes of six cases under the writer's care. In some of these great benefit was derived from repeated counter-irritation over the seat of developed pain. It is stated that several of the cases support the prevailing views respecting the localization of motor function in the cortical substance.

The mode of practicing percussion of the skull is described. The physician should be careful to make the taps of the finger as nearly as possible of equal force, except in the temporal region, where they should be somewhat lighter. It is well to percuss one's own head previously, to ascertain the character of the tap which can be borne without discomfort. It is advised to avoid, either by remark or otherwise, directing the patient's attention to any particular part of the head, particularly if they be of an impressible or hysterical disposition.

It is not claimed that this means of diagnosis will be of very wide application. It probably will not be of service if the morbid action be diffused, as in ordinary cases of insanity. It is chiefly of use where the disease is limited in extent, and particularly if it is attended by gross products, such as inflammatory lymph producing local tension, or tumors of the surface or in the membranes. In injuries of the head it may occasionally be of service. Thus in a somewhat doubtful case of fracture of the skull the writer has seen it assist in marking out the line of the fracture. In disease of the inner table of the skull, when the pain of the head is widespread, it may help to localize the lesion.

Wherever, therefore, there is the least ground, judging from the general symptoms, for suspecting that disease may exist superficially within the skull, percussion of the head should not be omitted. It may yield most valuable information, on which important local treatment may be based.

On Certain little-recognized Phases of Tabes Dorsalis (Locomotor Ataxy)—Thomas Buzzard, M.D., F.R.C.P., London.

Attention is drawn to the overwhelming prominence among the symptoms which has been given both by Romberg and Duchenne (de Boulogne) to the incoördination of movement often observed in tabes dorsalis. In consequence of this, the symptom (which is very frequently absent) has come to be regarded as the essential one, and to many persons the idea never occurs that a patient who has no ataxy may be an example of the disease. So it comes to pass that any one symptom which happens to be more than usually prominent is apt to absorb the attention, and the ailment is probably referred to some widely-different pathological condition. The author accepts West-

phal's symptom (the absence of the knee-phenomenon), along with good voluntary power in the anterior muscles of the thigh, as almost positive evidence of the existence of tabes dorsalis when it is associated with any one or more of the recognized symptoms. In illustration of the tendency there is for tabes to be overlooked if no ataxy be present, he relates five cases in which the *crises gastriques* (of Charcot) were so strongly marked as to monopolize attention, which would hardly have happened had the symptom from which Duchenne named the disease been present. In one of these the author found absence of knee-phenomenon, pupils small, contracting in accommodation but not to light, lightning pains, along with the gastric crises; but this latter symptom was so predominant that the case was subsequently pronounced by others to be one of cancer of the stomach, notwithstanding that the gastric symptoms had existed paroxysmally for fifteen years. In another, correctly diagnosed as tabes dorsalis, and shown to him by Mr. Herbert Page, to whom the patient had applied on account of joint-disease in the foot, there was a history of obstinate vomiting and epigastric pain of at least three months' duration. (The case afforded another example of that remarkable association of tabetic arthropathy with gastric crises to which the author directed attention in February, 1880.) It is suggested that many cases of so-called "gout in the stomach" may probably be examples of the gastric crises of tabes, as well as some which are supposed to be due to intestinal obstruction.

A like prominence of some other symptoms of tabes may equally absorb attention. Pierret's view that the disease is essentially a chronic inflammation of sensory fibers is adopted, and it is urged that just as optic atrophy may be the dominating symptom in some cases, so atrophy of the auditory nerve may be the prominent one in others, and thus many cases of so-called "nervous deafness" may prove to be examples of tabes dorsalis. Reference is made to a case in which stone in the bladder was the first symptom of tabes dorsalis. The bladder trouble may be more than usually pronounced, and lead to retention of urine and accumulation of mucus, in which a phosphatic calculus is easily formed. The urgent symptoms produced by this will easily conceal the general disorder which lies behind.

On Addison's Disease—Edward Headlam Greenhow, M.D., F.R.S.

Cases of disease of the supra-renal capsules published previous to Addison's discovery:

Typical case, previously unpublished. Points in which it agreed

with or differed from the usual characters of Addison's disease, as regards—

*A*. The bronzing of skin.

*B*. The constitutional symptoms.

*Constitutional Symptoms.* Those of extreme nervous depression, with feeble action of the heart; small, thready pulse; faintness; shallow, feeble breathing; breathlessness, and often gasping and sighing on making any effort; hiccup; anorexia; irritability of stomach; retching; and sickness. Temperature usually sub-normal. Apparent decrease of tissue-change, and, in uncomplicated cases, neither emaciation nor anemia. Death by asthenia; sometimes sudden; at other times preceded by incoherence, delirium, subsultus, and convulsions.

*Bronzing of Skin.* Dusky brownish or greenish brown discoloration of skin, most marked on the face and hands, around the nipples, in the axillæ, groins, genitals, over the abdomen, and in seats of local irritation caused by blisters, wounds, or abrasions of the surface. Darker parts of skin merge insensibly into lighter, excepting where any local irritation has existed, when the margin of discoloration is often very distinct; but true cicatricial tissue retains its white, ivory appearance. Lips, tongue, and mucous membrane of the mouth often present patches of discoloration, and in these situations the margin is usually well defined. On microscopical examination the pigment is found to be deposited in the deeper layers of the rete mucosum and in the lower cells of the mucous membrane, immediately overlying the papillæ.

*Pathological Appearances.* Invariably of the same kind. The supra-renal capsules are hard and nodulated, or uneven, misshapen, and usually enlarged, though in rare instances they have been found smaller than natural; adherent to adjoining parts and surrounded by a dense mass of connective tissue, in which the neighboring nerves, ganglia, and plexuses are involved. On section the normal structure is generally found entirely destroyed, the cut surface presenting a marbled appearance, from the presence of two dissimilar materials—the one firm and semi-transparent, of a gray or a grayish-green color; the other opaque, of a yellowish or cream color, and of caseous consistence. In a few cases this material has been found softened down into a creamy fluid; in others it has been hard and gritty.

Under the microscope the semi-transparent, gray substance is seen to be formed of a fibrillated stroma containing numerous lymph corpuscles. The opaque, cheesy substance consists of amorphous, granular matter, shrunken cells, nuclei, and oil. The pathological process

therefore consists of an inflammatory exudation which encroaches upon and destroys the natural tissue of the capsules, and terminates in caseous degeneration. This is accompanied by great proliferation of the surrounding connective tissue. The adjoining lymphatic glands are generally enlarged, and there is often swelling of the agminated and solitary glands of the intestines, and mammillation of the mucous membrane of the stomach, with growth of lymphoid tissue around the gastric tubules. In some cases enlargement of spleen has been observed, and also caries of vertebræ and abscesses in the vicinity of the capsules, and very frequently caseous deposits in the lungs and other organs.

The course of the disease is chronic, and often varied by exacerbations and remissions; but the tendency is always toward a fatal termination. The constitutional symptoms and bronzing of skin do not always run parallel. Sometimes the one and at other times the other precedes or makes the more rapid progress.

*Diagnosis.* Not difficult in typical cases, but spurious bronzing is a frequent cause of erroneous diagnosis. Such discoloration occurs in "vagabond's disease," in very chronic phthisis, in leukemia, and in lymphadenoma. Abstract of a very remarkable case of the latter recently published by Dr. Paget, of Cambridge, with comments.

*Causes of the Disease.* Usually very obscure, but sometimes it has obviously taken its origin from extension of the inflammatory process from disease or injury in the neighborhood of the supra-renal capsules.

*Pathology.* The symptoms of Addison's disease are not due to the destruction of the capsules and abrogation of their proper function, for in some recorded instances their normal structure must have been destroyed by the pathological process of the disease itself previous to the development of the symptoms; and it has often been entirely supplanted by cancerous deposit without the occurrence of these symptoms. On the contrary, it seems almost certain that the symptoms are to be attributed to the damage done by the pathological process to the nerves which pass into the capsules, especially the branches of the pneumogastric nerve, and to the neighboring nerve-plexuses and ganglia, which are compressed by the contracting adventitious tissue in which they are imbedded. The discoloration of the skin is probably due to the injurious effects of similar pressure upon the nerves of the sympathetic system, and, as shown by Dr. Paget's case, may exist where the supra-renal capsules are healthy; but these nerves are imbedded in and compressed by adventitious growth. This fact suggests for the future a careful study of cases of pigmentation of skin, unac-

companied by Addison's disease, in reference to the condition of the nerves, ganglia, and plexuses of the sympathetic system.

ON THE ORIGIN AND CURE OF SCROFULOUS NECK—T. Clifford Allbutt, M.A., M.D., F.R.S.

The purpose of the paper is to insist on the local causation and the local development of many cases of scrofulous neck. The primary importance of local means of cure follows as the practical application.

While giving due weight to the undoubted influence of heredity in favoring this malady, yet that such states may be and often are set up in young persons by local causes alone is equally indubitable. Moreover, local causes play a large part—perhaps the chief part—in producing the malady in those originally strumous. A careful survey of causation will show that artificial scrofula is at least as common as the natural.

Of local causes, irritation of neighboring mucous membranes is the most common, such as the pharyngeal and the aural-pharyngeal irritations being far the commonest antecedent, and the septic kind of these the most effective. The glandular enlargements are thus bubonic, and secondarily by caseous degeneration become themselves the foci of further like mischief.

A thorough knowledge of these facts will lead to prevention, perhaps may lead to complete prevention of scrofula properly so called. Its cure is acknowledged to be tedious and unsuccessful, the reason being that treatment is too exclusively directed to the supposed constitutional origin.

After minute inquiry into possible morbid influences acting through the mucous membranes, a rapid and complete cure without disfigurement must generally be sought by surgical means. Free incision and enucleation of caseous deposits are essential. The softening mass under the jaw is usually a subcutaneous abscess with more or less thickened walls, which depends upon infection from the deeper-lying caseous glands. With these it communicates by sinuous channels, often very obscure. Upon the laying open of these and the clearing out of the inner foci care and future safety depend.

Many cases follow, in which Mr. Teale has coöperated with the author in carrying out these principles.

WHAT IS THE CLINICAL VALUE OF THE EXAMINATION OF THE URINE IN BRIGHT'S DISEASES?—Prof. Grainger Stewart, M.D., Edinburgh.

*a.* Quantity. Diminished: 1. In inflammation (early stage and

during exacerbations). Normal: 1. In middle stage of inflammation; 2. In earlier stage of cirrhotic. Increased: 1. In waxy throughout (unless interfered with), and preceding even the albuminuria; 2. In cirrhotic—later stage; 3. Sometimes in advanced inflammation and during absorption of dropsies. Suppressed: In inflammation acute and advanced, and in cirrhotic advanced.

*b.* Specific gravity and solids. Influenced: 1. By amount of water; 2. By amount of urea; 3. By amount of other solids; Urea in different forms.

*c.* Albumen, serum-albumen, the only very important form. Quantity in the different forms; Explanations.

*d.* Blood. 1. Early inflammation and acute exacerbation; 2. Very rarely in waxy; 3. Occasionally in late cirrhosis with other hemorrhages.

*e.* Tube-casts. Varieties; Different views as to the origin; Abundant and varied in inflammation; Few in waxy; Few in cirrhotic.

On Local Treatment of Diphtheria—Dr. Morell Mackenzie, London.

1. *Ice* useful in first stage, both internally and applied externally to the neck, contra-indicated when it causes pain, in young children, in advanced stages, and especially if gangrene be present.

2. *Steam inhalations* of great service when the false membrane shows a disposition to separate, and when it is situate in the larynx or trachea.

3. *Solvents* administered by swabbing or in the form of spray often highly beneficial. Lime-water and lactic acid the best.

4. *Antiseptics very important*—carbolic acid, permanganate of potash, and chloral hydrate; the last being the most certain.

5. *Antaerics* or *varnishes;* that is, remedies which exclude the air from the false membrane. Tolu dissolved in ether is the most serviceable. Simultaneous employment of other local remedies (ice, steam) not prevented by the use of these agents.

6. *Caustics* are always injurious, while *astringents* are useless and sometimes hurtful.

Dr. A. Tobold, Berlin.

Diphtheria undoubtedly a constitutional disease produced by a specific contagium with local pseudo-membranous inflammation of upper air-passages. Importance of attending to the local processes, while not neglecting constitutional treatment. Historical review: for-

merly, destruction of membranes by means of caustics advocated; all known caustics used; bad, or at any rate unsatisfactory results. Later on local employment of resolvents in form of gargles, inhalations, etc. But little influence of the much-recommended lime-water. Lactic acid better, but not very satisfactory either. Best resolvent at present known is *moist warmth* in the form of vapor inhalations, with the addition of antiseptics. Astringents and flowers of sulphur of little avail. Ice internally useful.

Conclusions:

1. At the outset of the attack ice internally, ventilation, isolation.

2. If temperature be high, cold packing of body or neck, or half baths, very necessary.

3. If false membranes be present in upper air-passages, application of resolvent and disinfectant remedies for cleansing purposes. In adults, gargles and inhalations; in children, injections by means of a syringe. If cleverly managed they may also be used by means of soft straight big brush, which is each time to be well cleansed and disinfected.

4. Use of caustics is to be absolutely repudiated, as is

5. Mechanical removal of the false membrane.

Mr. Lennox Browne, London.

Experience of so-called solvents. Preference to lactic acid. The constant use of ice and of beverages containing chlorate of potash, the last measure acting constitutionally as well as locally.

Removal of enlarged tonsils advocated even during an attack of diphtheria, as a local measure calculated to have the best results, (1) as removing an impediment to the respiration, (2) as preventing the downward progress of exudation, and (3) as an early substitute for or prevention of the more dangerous measure of opening the windpipe.

Nature and Treatment of Ozena—Dr. B. Fraenkel, Berlin.

1. Under the name "ozena" of olden times different diseases of the nasal cavity have been comprised, the common symptom of which is a fetor originating from the nose and communicated to the respired air.

2. The most common form of ozena to which therefore this name ought to be limited occurs without disease of the bones and cartilages and without ulcerations of the mucous membrane. It comes under the head of chronic catarrh of the nasal cavity, and is always connected with more or less extensive atrophy of the mucous membrane.

The fetor in this form is due to the stagnation and decomposition of the secretions. It is not *per se* a proof of the presence of a constitutional disease.

3. Of methods of treatment of this form of ozena those which have been found to be most trustworthy are—

(*a*) The freeing of the nasal cavity from secretions by means of the syringe or douche.

(*b*) Gottstein's tampon.

(*c*) The cautious use of white heat to destroy the suppuration of the mucous membrane.

Dr. E. Fournié, Paris.

Accidental and constitutional ozena. Former due especially to syphilitic, diphtheritic, or catarrhal inflammation. Fetor not so bad as in constitutional ozena. Treatment, besides general measures:

1. Frequent injections of warm decoctions of althea and poppy. If crusts have been formed, mechanical removal by means of sponge is necessary.

2. Topical applications, according to nature of lesion, of solutions of nitrate of silver, carbolic acid, tincture of iodine. Constitutional ozena much more serious and difficult to cure; difficulty of recognizing nature of the affection; positively known only that it occurs from the age of three to four or later, and generally in scrofulous or herpetic individuals. Cause of the specific fetor, according to the author, to be found in a specific property of the glands of the naso-pharyngeal mucous membrane. Analogous specific properties of glandular secretions relating to smell found in other parts of the body. *Complete absence of deep ulcerations* in ninety-two cases examined by the author. Description of the two forms seen by him: (*a*) *Dry form;* that is, ozena without catarrh, slight excoriation and congestion of the mucous membrane; in the neighborhood of the posterior nares a blackish, firmly-adherent covering; this form generally found in herpetic individuals. (*b*) *Humid form*—the most frequent one. Description of the appearance of the parts, seat of predilection of the manifestation according to the author, circumference of the posterior nares.

*Treatment.* 1. *Constitutional.* In the humid form, three to four times yearly methodical use of sulphur baths; internally at the same time alternatively cod-liver oil, iodide of potassium, iodide of iron. In the dry form, alkaline arsenical baths more suitable, with arsenic and bicarbonate of soda internally.

2. *Local.* Injections as above once or twice daily, followed by

injection of two per cent solution of salicylate of soda every two or three days; mechanical removal of crusts, followed immediately by cauterization with a strong solution of nitrate of silver (one to five). Localized application to the diseased spots by means of laryngeal mirror and nasal speculum necessary. Duration of treatment, on the average, three weeks. Tendency to recurrence after one to two months, repetition of treatment; if necessary, repeated several times. Lasting success often obtained only after treatment from six to twenty-four months.

Dr. Justi, Idstein am Taunus.

1. Ozena not a disease *per se*, but only a symptom.

2. This can be produced by all diseases which either augment or change the secretion from the nasal mucous membrane, and which produce, in consequence of stagnation, a decomposition of the secretion.

3. Such diseases are: Chronic inflammation of nasal mucous membrane, foreign bodies, nasal and naso-pharyngeal tumors, specific and non-specific ulceration of the nose, and disease of the bony parts of the nose.

4. According to the multiplicity of the causes the treatment must vary, and must often be not only local, but also constitutional. The most important indication is to promote the free evacuation of the discharge.

Dr. H. Guinier, Cauterets.

Specific odor not necessarily dependent on ulcerative processes. With removal of the offensive crusts often present in such cases the odor—that is, the most disagreeable symptom—will disappear, even if a radical cure be not effected. This removal is best carried out by means of the laryngo-nasal gargarism as recommended by the author.

On Chronic Discharge from the Nostril and Ozena—Mr. W. Spencer Watson, London.

Any chronic discharge may be an occasional cause of ozena.

Ozena most commonly associated with lupus erythematosus of the nostril; congenital syphilis and a condition allied to phthisis pulmonalis. Rarely associated with bone-disease. Chronic eczema sometimes a cause.

Diagnosis of causes of ozena depends on (1) age, (2) physiognomy,

(3) family history, (4) rhinoscopic inspection, (5) results of treatment, (6) general symptoms.

*Treatment.* Weber's douche only as a preliminary and to remove obstruction. Topical medication, sprays, iodoform pencils, snuffs, etc. Internally arsenic, iron, cod liver oil, and iodides. Occasionally use of caustics.

Chronic catarrhal discharges, if serous or sero-purulent, controlled by snuffs of bismuth, copaiba, and mineral acids internally.

RESULTS OF THE MECHANICAL TREATMENT OF LARYNGEAL STENOSIS—Dr. Paul Koch, Luxemburg.

1. Catheterism and "tubage" of the glottis are to be rejected in cases of acute laryngeal stenosis as soon as these latter endanger life. This rule is especially to be applied in cases of children suffering from croup, diphtheria, and edema glottidis. Catheterism and "tubage" can not in any respect replace tracheotomy.

2. In cases of chronic laryngeal stenosis the first question will be whether the morbid process has arrived at its end; if not, the appropriate general treatment should be employed, and the final development of the laryngeal affection must be waited for.

3. In cases of chronic narrowing which do not endanger life, mechanical treatment can be employed from the very beginning; but if there is the slightest danger in delay, prophylactic tracheotomy ought to be practiced forthwith.

4. The low operation of tracheotomy should always be performed in these cases.

5. If free respiration, either *per vias naturales* or through the artificial opening, is secured, the mechanical treatment might be executed, either through the mouth or through the tracheal fistula.

6. If mechanical treatment is unsuccessful, recourse must be had to prophylactic tracheotomy and to laryngotomy, followed by excision, galvano-caustic cauterization, etc.

7. If laryngotomy and the subsequent treatment are not sufficient, they should be followed by partial resection, and introduction of either a T canula or of an artificial larynx.

RECENT ADVANCES IN ABDOMINAL SURGERY—Lawson Tait, Esq., F.R.C.S.

The author draws attention to certain advances in abdominal surgery, which he regards as the outcome of the increase in the success

of ovariotomy, which he attributes to increased attention to hygiene and to the intraperitoneal method of operating.

He has, in papers already published, laid down the principle that every clearly non-malignant tumor of the abdomen or pelvis which presents a likelihood of destroying the patient, or which, by reason of suffering caused by it, greatly interferes with the comfort of life, should be investigated by an exploratory incision. Acting upon this, he has opened the abdomen in many cases which until recently were not regarded as within the province of surgical effort. Among these were included one case of gallstone, five cases of hydatids of the liver, one case of large cyst of the liver, six cases of cysts of the kidneys, one case of abscess of the spleen, twelve cases of abscess of the pelvis, four cases of suppuration of the fallopian tube, and six cases of fallopian pregnancy. Of these thirty-six cases only one died, that being a case of fallopian pregnancy, in which the child is still living, the mother being at the time of the operation too far exhausted for recovery to be hoped for.

The principles of the operations in such cases were: First, to operate before the patient was hopelessly exhausted; secondly, to open the abdomen carefully in the middle line; thirdly, to take the utmost care that none of the contents of the cavities attacked should be allowed to enter the peritoneal cavity; fourthly, to completely close the peritoneal cavity under all circumstances, that being done by uniting the wound in the tumor by a continuous suture to the wound in the abdominal wall when it was necessary to drain the cavity; fifthly, scrupulous attention to the proper isolation of the patient from all insanitary and poisonous influences. The author has in a few of these cases attempted to employ the Listerian details, but he found them cumbrous and impracticable, and that the patients recovered perfectly well without them, and that the employment of carbolic acid rather impeded recovery than aided it.

Laparotomy and Cystorrhaphy in Cases of Perforating Wound of the Bladder — Dr. E. Vincent, Lyons.

Results of a new series of experiments performed upon rabbits, and conclusions deduced therefrom:

I.

1. The contact of urine with the peritoneum is not such a fatal accident as is usually supposed.

2. Suture of the bladder by interrupted metallic stitches, the serous

surfaces being brought into contact and the stitches left in the abdomen, may be practiced with almost a certainty of success.

3. Whatever the cause of rupture, the animal can almost invariably be saved if the vesical suture be practiced immediately or within a very short time, even if grave complications be present.

4. The animal may be saved even if considerable time be allowed to elapse after the injury.

5. When the operation was delayed longer than sixteen hours some animals died from urinary intoxication without true peritonitis. Others survived owing to a spontaneous closure of the opening in the bladder.

6. The spontaneous closure is exceptional, and therefore laparotomy and cystorrhaphy should be at once practiced.

II.

Taking into consideration these and previous experiments, and the result of a case in which a large piece of the bladder was excised accidentally during an ovariotomy, the author would formulate the following propositions as applicable to the human subject:

1. Considering the almost invariable mortality which follows wounds of the bladder, however produced, laparotomy and cystorrhaphy should be resorted to immediately. The chance of success diminishes in proportion to the length of time that has elapsed since the accident.

2. As the employment of antiseptic means has removed the danger of operations involving the peritoneum, ought we not to prefer suprapubic lithotomy to any of the perineal methods, retaining only two operations for stone—lithotrity, if it be friable and small; suprapubic lithotomy, if it be very large or hard.

A Successful Case of Nephrectomy—R. Clement Lucas, London, F.R.C.S.

The patient on whom this operation was performed is a man thirty-six years of age, of fair complexion, and somewhat spare. His father died of phthisis. He had been a sailor, and had had fever in India, but of late years was employed as a bricklayer.

In September, 1874, he was in a medical ward of Guy's Hospital, suffering from pain in the left loin. His urine contained pus and albumen. An abscess formed in the left loin, which was opened, and a quantity of fetid pus escaped. He left the hospital with a sinus, which did not heal. He was admitted a second time into Guy's Hospital on November 26, 1879, under the care of Mr. Lucas. He stated that dur-

ing the five years since he left the hospital pus had continued to escape from the sinus (which lay half an inch below and one inch behind the extremity of the last rib), but that for the last two months urine as well as pus had escaped, making him very sore and uncomfortable. He has great pain in micturition, which lasts twenty minutes after the act. His urine contains a considerable quantity of pus. He is pale, weak, and much wasted. He was kept under observation until February 17, 1880, when, Mr. Lucas having come to the conclusion that the right kidney was doing all the work, determined to excise the diseased one. A vertical incision in the loin was first made, but to obtain more room this was enlarged transversely at the upper part. The kidney was so adherent to the ribs that it had to be detached by a blunt-pointed bistoury. The capsule was left. A portion of ureter removed was enormously thickened. The operation was performed antiseptically. All went well till about the fourteenth day, when secondary hemorrhage occurred. It was at first controlled by pressure, but when it recurred the wound was opened up, and an attempt was made to re-apply a ligature to the pedicle. Hemorrhage recurred again and again till the man's life was despaired of, but at last it was controlled by large sponges steeped in perchloride of iron thrust in the wound and firmly bandaged in position. He was so much exhausted by the loss of blood that he could not turn in bed, and in spite of every care acquired a slight bed-sore. His convalescence was consequently protracted. The urine for many months after the operation contained a large quantity of pus, but this gradually diminished. He went to Brighton for change of air on July 30th, where he was kindly attended by Mr. Couling. After his return to town he rapidly gained flesh, and a sinus which remained closed finally about the end of the year. He is now in good health, free from pain, and able to work. The relief obtained is perhaps the best indicated by the fact that he is nearly two stones heavier than he was before the operation.

# Notes and Queries.

SIR WILLIAM MACCORMAC.—All who attended the International Congress held in London will be glad to know that Her Majesty Queen Victoria has been pleased to confer the honor of knighthood on Mr. MacCormac, the Honorable Secretary-general of the Congress. To Mr. MacCormac more than to any other one man was the success of the Congress due. His labors in its interests were simply enormous. To administrative ability of the highest order he added unwearying patience and unvarying suavity of speech and manner.

Mr. MacCormac is in the very prime of life, being just forty-five years old. His father, Dr. Henry MacCormac, of Belfast, Ireland, is a physician of deserved eminence, and though nearly forty years the senior of the son, yet retains great vigor of mind and body, and is a noble specimen of the gentleman of the olden time.

The following brief sketch of the life and services of Sir William MacCormac may interest our readers:

Mr. MacCormac distinguished himself as a student in the Queen's University, Ireland, and was elected surgeon to Royal Hospital, Belfast, in 1864. In 1870, on the outbreak of the Franco-German war, Mr. MacCormac immediately volunteered his services, and was nominated by the French minister of war for duty in one of the hospitals of Metz. He was afterward appointed surgeon-in-chief of the Anglo-American Ambulance, which, under his direction, both during the battle of Sedan and subsequently, was able to render signal services to the wounded of both nations. He embodied the results of his war experience in an interesting volume entitled Recollections of an Ambulance Surgeon—a work which was honored by a commentary upon it by the veteran military surgeon Professor Stromeyer, and was translated into German, French, and Italian. On returning to England Mr. MacCormac was elected to the Fellowship of the Royal College of Surgeons of England, and shortly afterward surgeon and lecturer

on surgery to St. Thomas's Hospital. In 1876, as chief surgeon of the National Aid Society, he accompanied Sir Robert Loyd-Lindsay to the seat of war in the East, and there superintended the distribution of English surgeons and medical stores sent out by the society to assist in the care of the wounded of the Turkish and Servian armies. In 1877 his military medical experience was largely utilized by the Stafford-house Committee in the conduct of their extensive operations in the East, and he was mainly responsible for the selection of the surgeons sent to the seat of war by that committee. For services thus rendered in foreign countries Mr. MacCormac has received several decorations, including the Legion of Honor, the Crown Order of Prussia, the Ritter-Kreuz, first class, of Bavaria, the third class of the Medjidie, and the Cross of Commander of Takova of Servia. In 1880 Mr. MacCormac published a treatise on Antiseptic Surgery, which has been translated into French, German, Dutch, and Russian. He has held office as member of the Senate and examiner in surgery in the Queen's University, Ireland. He is examiner in surgery at the University of London, consulting surgeon to the French Hospital, London, and to the Royal Hospital, Belfast, and the author of many papers in the Transactions of medical societies.

These are services which certainly deserve recognition by the government. But Mr. William MacCormac was to all who knew him a knight from spur to plume before letters-patent made him so.

THE UNITED STATES STILL AHEAD!—The following is said to be the proportion of physicians to each ten thousand inhabitants in various countries:

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|---|---|
| France, | 2.91 |
| Germany, | 3.21 |
| England, | 6.06 |
| Austria, | 6.10 |
| Italy, | 6.10 |
| Switzerland, | 7.06 |
| United States, | 16.24 |

Eight times as many physicians in the United States to the thousand inhabitants as in France! This would almost seem to confirm the statement of a humorous lawyer at the Louisville bar who said that out in Bullitt County where he was raised

doctors were so thick that they rode two on a horse; and once when a flatboat rounded to for the night on Salt River that before morning two medicos had nailed their shingles to the masthead.

DEATH OF PROF. JOHN E. CROWE.—On Monday evening, September 27th, Dr. Crowe, previously in what seemed to be the most robust health, died suddenly of what was supposed to be cerebral apoplexy.

Dr. Crowe was born in Louisville, Ky., in 1829. He grew up and was educated here. He taught for several years in the public schools of this city. He graduated in Medicine in the University of Louisville, in which institution he was appointed to the chair of Obstetrics in 1868. He filled the place acceptably to both student, trustee, and the public up to the day of his death. He was a pains-taking, earnest teacher. He acquired a very large practice. He was an eminently charitable, kindly, generous man, whose professional services, liberal hand, and cheery words will be sorely missed by a very large circle of friends.

THE leaders of battalions fall fast. Dr. Jas. White, of Buffalo, died suddenly and in his very prime; Dr. Lloyd Howard, of Baltimore, young, earnest, full of enthusiasm, made a misstep, fell between two boats, and was drowned; Dr. Warren Greene, of Portland, Maine, full of years and honors, died in mid-ocean while returning from Europe, and was buried in the sea—all within the early weeks of an autumn not yet gone.

THE CHAIR OF OBSTETRICS IN THE UNIVERSITY OF LOUISVILLE.—The Board of Trustees of the University appointed Dr. Theophilus Parvin, of Indianapolis, to the chair of Obstetrics and Diseases of Women, made vacant by the death of Dr. Crowe. The friends of the University every where will be gratified to know that so eminent a man and so attractive a teacher as Professor Parvin has again been added to its corps of instructors.

AMONG the many generous words spoken in many different quarters of the appointment of the junior editor of this journal to the chair of obstetrics, etc. in the University of Louisville, none have been more terse than the following from the distinguished editor of the Philadelphia Medical Times:

A better choice could not have been made, and we most heartily congratulate both college and professor.

DR. L. S. MCMURTRY.—Dr. McMurtry, of Danville, Ky., a very valued contributor to the AMERICAN PRACTITIONER, a physician of varied learning and accomplishments, has been called to the chair of Anatomy in the Kentucky School of Medicine. The trustees of the school could not have made a better selection. It is understood that Dr. McMurtry will remove to Louisville in January next and engage in general practice. His loss will be keenly felt in Danville, his old home; but Louisville will afford him a larger field for usefulness and distinction.

AMERICAN PUBLIC HEALTH ASSOCIATION.—The ninth annual session of the American Public Health Association will be held at Savannah, Georgia, beginning November 29th and continuing four days. It is expected that the meeting will be large. The subjects that legitimately come before the Association are of importance to every section of the Continent, and will, we doubt not, be brought forward and discussed in a manner which will inure to the public good.

Savannah is a quaint, delightful old town, the home of many charming people, and the time selected for the meeting of the Association is a pleasant one for visiting them.